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ABSTRACT

This compendium of current practices contains descriptions of urban maternal and child health (MCH) programs. Many of the programs profiled have not been evaluated formally, but the profiles provide a starting point for examining what really works in MCH programs. Most of the 92 profiles are about improving access to care for urban children and families (60 programs, or 72% of profiles) or about strengthening urban public health systems for MCH (55 programs, 66% of the profiles). Five broad themes emerge from this group of profiles: (1) the importance of collaboration in community change; (2) understanding effective action; (3) building on community assets; (4) making joint investments in building human resources capacity; and (5) the importance of quality of service and information dissemination. Each profile describes the program, the obstacles it faced, and the lessons learned. Profiles are indexed by type of initiative and by essential MCH functions performed. Appendixes list CityMatCH membership and publications. (SLD)

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Lessons Learned 1997

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

From the CityMatCH Urban MCH Leadership Conference

U.S. Department of Health & Human Services
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau

CityMatCH

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of Nebraska
Medical Center

UD033352

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Lessons Learned 1997:

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

From the CityMatCH
Urban MCH Leadership Conference
Atlanta, Georgia
September 1997

Editors
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Maureen Fitzgerald, MPA

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City**MatCH** is a national organization of urban maternal and child health programs and leaders. City**MatCH** was initiated in 1988 to address the need for increased communication and collaboration among urban and maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. City**MatCH**, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. City**MatCH** also has developed a centralized information base about the current status of maternal and child health programs and leaders in major urban health departments in the United States.

For more information about City**MatCH**, contact Dr. Magda Peck, City**MatCH** Executive Director/CEO, Department of Pediatrics, University of Nebraska Medical Center, 982170 Nebraska Medical Center, Omaha, NE 68198-2170, Phone: (402) 559-8323 or visit us at our website http://www.citymatch.org.

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1997-1998
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Dear Colleague:

"Lessons Learned 1997: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health" is the second of a new publication series from City**MatCH**, the national organization of urban maternal and child health (MCH) programs and their designated MCH leaders in local health departments serving America's cities. It is designed to facilitate easy access to selected urban public health practices and promote communication across communities about what works, what doesn't work and why.

The intent of this compendium of current practices is to put ideas forth for consideration, with the understanding that readers have the capacity and responsibility for following up on initiatives of interest.

While many of these urban MCH profiles have not been formally evaluated to assess impact or outcomes, they provide a starting point for examining further what really works. Each City**MatCH** member health department attending the September 1997 Urban MCH Leadership Conference was requested to submit a profile describing what it judged to be its most successful MCH effort.

Every local health department submitting an urban MCH profile deserves special recognition for passing on valuable "lessons learned" and for trying to impact the health of children and their families in urban communities. City**MatCH** staff, too, deserve kudos for their hard work in designing a user-friendly tool for broader use. Final thanks to the Maternal and Child Health Bureau, HRSA, for providing the essential funding to allow City**MatCH** to serve as a partner for information and communication.

We hope this forthright peer exchange can plant seeds of changes across cities struggling with similar MCH concerns. Please let us know if this publication has proven useful in your work in making a difference for women, children and families.

Sincerely yours,

Magda G Peck

Magda G. Peck, ScD
CEO/Executive Director, City**MatCH**

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Summing Up: What Lessons Have We Learned?

There continues to be a call for innovative approaches and "best practices" to solve the public health problems facing women, children and adolescents in America's cities. Urban communities want to know how to overcome barriers to implementation, how to go from "project" to scale, and how to sustain resources and commitment for long term change. For several years, CityMatCH has been collecting and disseminating information about promising program and policy initiatives in urban maternal and child health (MCH) to address the demand for replicable solutions. One longstanding requisite for receiving subsidized registration and lodging at the annual CityMatCH conference is local health department submission of a "profile" of innovative MCH practices. The written profiles are exchanged to stimulate frank discussion among the designated urban maternal and child health leaders in attendance about successful approaches and lessons learned.

Lessons Learned in 1996

- ◆ *Effective collaboration is essential for success.*
- ◆ *Community-wide MCH collaboration is hard work.*
- ◆ *Effective communication starts at home.*
- ◆ *Greater urban health department MCH capacity is needed to get the job done.*
- ◆ *Projects are not the same as ongoing, sustainable programs.*
- ◆ *Recycle and replicate good ideas.*
- ◆ *Strategically build and manage resources for MCH in cities.*
- ◆ *Accountability is key.*

Each of the profiles submitted in 1997 has been edited, updated, and indexed in this edition of *Lessons Learned.* Most of the 92 profiles featured are about improving access to care for urban children and families (n=60, 72%) and/or strengthening urban public health systems for MCH (n=55, 66%).[1] Over half of the submitted profiles focused on three of the ten essential MCH functions: promoting positive beliefs, attitudes and behaviors (n=53, 64%); linking MCH populations to services (n=51, 61%); and assuring the capacity and competency of the public health workforce (n=45, 54%). Most promising practices relied on a mix of private and public funding. Nearly half (48%) of submitted profiles outlined initiatives funded in part by local government resources; one-third (33%) had funding from private sources (33%). Nearly a third (31%) of initiatives profiled were supported in part by MCH Title V Block Grant dollars.

The final profile question asks ***"What is the greatest lesson your health department has learned and can share with others about this activity?"*** *Lessons Learned 1996* described eight broad learning themes about collaboration, communication, capacity-building, sustainability, recycling /replication, resources acquisition, and accountability,[2] some of which echo in 1997. Five broad themes emerge from this group of profiles. Overall, there is a growing awareness of what it will take to make a long term, sustainable difference in the lives of urban women, infants, children and adolescents.

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◆ 1

Lesson Learned:

Long term change requires community partners with shared vision who will invest in effective, ongoing collaboration to achieve shared goals.

"The price of collaboration is time... commitment must be ongoing."

-Madison (WI) Department of Public Health

Urban health departments nationwide have firmly discovered that they cannot make a significant difference alone. Collaboration has become a recognized requisite for sustainable, long term change. Most of the leading health issues facing urban families and children - violence at home and in the community, persistent under-immunization of preschool children and adolescents, adolescent pregnancy and parenting, and under-insurance - require the engagement of many disciplines and sectors to identify and implement workable solutions. The hard lesson being learned across cities is just how much time, patience, and commitment true collaboration requires of all partners. *"The community process takes time, care and nurturing,"* the Spokane (WA) Regional Health District observed about its work to establish an immunization registry. It also is hard work. St. Paul-Ramsey County Department of Public Health cautions that *"collaborations involving for-profit entities as well as non-profits and government are more difficult to implement and reach outcomes."* In providing pediatric health services to their community' homeless, the Vanderburgh County (Evansville IN) Health Department discovered that *"working in a collaborative situation all staff need lots of flexibility, patience and a sense of humor."* Sums up the Milwaukee (WI) Health Department: *"Collaboration needs vision, leadership and consistency of purpose ...It's worth all the work."*

◆ 2

Lesson Learned:

Making a measurable difference in the health of urban children and families means knowing and mastering the difference between being 'right' and being effective.

"The political process is as important as the "content" of what you're trying to do."

- San Diego County (CA) Department of Health Services

Urban health departments are learning that good ideas are simply not enough. They must be savvy and strategic to be effective. They must invest in planning for systems change. They must model communication within their health departments, with community partners, and with the people they serve. *"Get buy-in from community leaders,"* counsels Lexington's (KY) health department, *"and build and document the case for additional programs before you start to seriously organize."* Through their community-wide needs assessment, the Orange County (CA) Health Care Agency learned that *"timing is everything — there are many good ideas, the key is finding the right moment with a receptive audience."* The City of Dallas Health Department summed it up: *"Bureaucracies exist in all institutions but they too can be overcome if vested partners are committed and willing to put in the time and effort necessary to achieve their common goal."*

We have found an overwhelming desire in people to want to help better the lives of children."

-Corpus Christi-Nieces County (TX) Public Health District

Through collaboration with new partners to solve complex problems, health departments in urban communities are discovering new community assets. The Division of Public Health Northern Health Services covering Wilmington DE found that *"some agencies are an untapped resource waiting to be discovered [to help] reach others in the community."* In Modesto CA, the Stanislaus County Health Services Agency learned from their Minority Health Coalition that *"there's a wealth of unidentified people with talent and skills waiting to be unearthed. The community has the capacity to resolve a lot of the issues they are faced with, but often just need the encouragement, technical assistance and tangible resources to assist them."* Boise ID is utilizing retired people who want to be volunteers in improving childhood immunization levels. Resources abound that have not yet been engaged.

3

Lesson Learned:

Discover, cultivate and build on community assets.

"We must ensure the competency of the public health and primary care workforce."

-District of Columbia Department of Health

Health departments are acknowledging the need to increase the capacity of their own staffs in new ways. The Monroe County (Rochester NY) Department of Health learned to involve and empower staff at all levels from front line to administrative and to keep everyone informed and updated at regular intervals. The San Antonio Metropolitan Health Department's initiation of written competency testing for their registered nurses in family health was a change to improve the delivery of quality care; its implementation was done with affected staff. Capacity building must extend across beyond the health department's walls. *"Training activities for Department staff are critically needed as serve as opportunities for communication among staff who rarely cross paths "* observed the Austin/ Travis County (TX) Health and Human Services Department in its efforts to improve staff training around substance abusing women. *"Without activities that bring together staff from HHS with staff from community substance abuse programs, referral efforts are less likely to be effective."* The key is to build team spirit and empower the workforce.

4

Lesson Learned:

Sustainable solutions will require joint investments in building the human resources capacity in new ways.

5

Lesson Learned:

Our work must be valuable and valued in the eyes of our customers to whom we are accountable.

"Quality of service and disseminating accurate and adequate information play a key role in maintaining satisfied customers."
- Baltimore City (MD) Health Department

Health departments are rediscovering the value of personal service, and the positive impact of seeing those they serve as their customers. In their immunization initiative, the Akron (OH) Health department learned that *"families are more compliant when they believe that providers care about them."* Chicago Health Department's Male Responsibility Program found that their *"peer educators felt proud of their new roles as community experts."* Berkeley (CA) Health Department agreed that *"working with youth toward a definitive product is invaluable."* Breaking outside old bureaucracies, city and county public health agencies are finding the power of personal quality service.

Learning is about discovery. Through their efforts in maternal and child health, city and county health departments are discovering valuable lessons in making a sustainable difference for urban families and children. CityMatCH encourages policy makers, community leaders, parents and providers, to build on these Lessons Learned in their work to improve maternal and child health in cities across America.

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[1] See Profile Indexes I and II for a complete listing of profiles by types of MCH activities and by essential MCH functions, beginning on page 19.

[2] Peck MG and Koenig DG (1996). *Lessons Learned 1996: Profiles of Urban Health Department MCH Efforts.* Omaha NE: CityMatCH at the University of Nebraska Medical Center.

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How to Use Profiles

What is a "profile"?

The annual City**MatCH** Urban Maternal and Child Health (MCH) Leadership Conference is a working meeting of invited urban MCH leaders representing member city and county health departments whose jurisdictions include one or more cities of 100,000 population (or the largest city in states not otherwise represented). A requirement of each invited health department is to submit a written "profile" of one of the health department's most successful MCH initiatives during the past year.

The profile includes a description of objectives, activities, barriers faced and overcome, health department roles, funding, accomplishments, and lessons learned (see sample on page 6). The designated MCH representative to City**MatCH** may only receive federal subsidy for conference expenses if their profile is received prior to the Conference. Invited health departments are encouraged to submit a profile even if they are unable to send a representative to the Conference. Copies of profiles are included in the conference participant resource notebook to facilitate immediate peer exchange.

Why are "profiles" published?

Since 1992, in response to interest in- and increasing demand for- "best practices" in public health, City**MatCH** has published edited urban MCH profiles as a core component of Conference Highlights. The profiles are published as a compendium of ideas to promote the exchange of information about perceived successful initiatives in urban MCH. City**MatCH** does not verify each profile, nor does it evaluate the initiative and efforts described. It is assumed that with the contact information provided, readers will follow up with the source health department to ask questions and secure essential additional information.

How are the "profiles" organized?

The profiles are presented in alphabetical order, by city and by state where the local health department is located. Each profile spans two pages, with standard headings boxed for easy reference. Contact information is listed at the beginning of each profile to allow direct follow up with the health department. The 81 city and county health departments submitting profiles for the 1997 Urban MCH Leadership Conference are listed on page 4. In 1993, City**MatCH** began to index the conference profiles using standard categories of MCH approaches and targeted MCH populations. This practice continues with the 1997 profiles. In addition, the 1997 profiles have been indexed by essential MCH program functions. Both Profiles Indexes, which appear on pages 10-17, are explained on the following page.

Using Profile Index I: Target Populations and Approaches

Profiles are listed in alphabetical order on the left margin, by city and by state where the health department is located. Each submitted urban MCH profile has been coded by City**MatCH** staff for up to 49 categories of activity. Categories applying to a profile are shaded across the row corresponding to the health department's city/state. Population-specific activities appear on the left sided page; systems-specific approaches are indexed on the right sided page. To determine all categories within a given profile, read across the both pages. To identify the range of initiatives within a given approach, read up and down. Columns have been numbered top and bottom to allow greater ease in reading the index vertically.

Using Profile Index II: Essential MCH Program Functions

Profiles are listed in alphabetical order on the left margin, by state and by city where the health department is located. Using the 10 Essential MCH Functions Framework developed by a working group of public health organizations under the direction of the John Hopkins University Child and Adolescent Health Policy Center, each health department coded its profile for up to 49 categories of MCH functions. The full list of functions appear on the "sample" profile form on the following two pages. MCH function categories applying to each profile are shaded in Profile Index II. To determine all MCH functions within a given profile, read across both pages in the row for its city/state. To identify the range of initiatives within a given MCH function, read up and down the columns, which have been numbered top and bottom to allow greater ease in reading the index vertically. These numbers also correspond to the MCH functions listed on the sample profile. More information about the MCH functions framework can be found in the publication, "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America", prepared by Holly Allen Grason, MA and Bernard Guyer, MD MPH at the John Hopkins University Child and Adolescent Health Policy Center, for HRSA/MCHB, AMCHP, ASTHO, City**MatCH** & NACCHO.

Comments and Feedback Welcome

City**MatCH** needs feedback on how these profiles are used and how useful they are to public health practice. Tell us your comments and let us know of your experiences using City**MatCH** Profiles of Urban Health Department MCH Initiatives through E-mail: citymch@mail.unmc.edu or complete the evaluation form located at the back of this publication and return it to: City**MatCH,** 982170 Nebraska Medical Center, Omaha, NE 68198-2170.

Ten Essential Public Health Services to Promote Maternal and Child Health in America[1]

1. Assess and monitor maternal and child health status to identify and address problems.

2. Diagnose and investigate health problems and health hazards affecting women, children and youth.

3. Inform and educate the public and families about maternal and child health issues.

4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

5. Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.

6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

7. Link women, children and youth to health and other community and family services and assure access to comprehensive, quality systems of care.

8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs.

9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services.

10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

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1. Grason, H. and Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," John Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Listing of Successful Leading Urban Health Department Initiatives in Maternal and Child Health

CityMatCH members attending the 1997 Urban MCH Leadership Conference were required to submit a profile outlining successful MCH initiatives.

The profiles describe objectives, partnerships, accomplishments, funding sources, barriers and measures of success.

The initiative did not have to involve direct service provision, but should have exhibited a strengthened capacity to serve children and families.

Each year, a CityMatCH committee reviews submitted profiles and presents a "*SpotLight*" award to those cities who have created outstanding, innovative and successful MCH initiatives. The 1997 recipients are **Lincoln, NE, Syracuse, NY, San Diego, CA and Fort Worth, TX**.

City/State	Page
Akron, OH*	20
Albuquerque, NM	22
Anchorage, AK	24
Austin, TX	26
Baltimore, MD*	28
Berkeley, CA	30
Birmingham, AL*	32
Boise, ID	34
Boston, MA	36
Chicago, IL	38
Cleveland, OH	40
Columbus, OH*	42
Colorado Springs, CO	44
Corpus Christi, TX*	46
Dallas, TX	48
Dayton, OH*	50
Denver, CO*	52
Detroit, MI	54
Durham, NC	56
El Paso, TX	58
Englewood, CO*	60
Evansville, IN	62
Fort Worth, TX	**64**
Fresno, CA	66
Gary, IN	68
Grand Rapids, MI	70
Greensboro, NC	72
Hartford, CT*	74
Honolulu, HI	76
Indianapolis, IN	78
Jackson, MS	80
Kansas City, MO*	82
Knoxville, TN*	84
Lakewood, CO*	86
Lexington, KY	88
Lincoln, NE	**90**
Little Rock, AR	92
Long Beach, CA*	94
Louisville, KY	96
Madison, WI	98
Miami, FL	100
Milwaukee, WI *	102
Minneapolis, MN	104
Missoula, MT	106
Modesto, CA	108
Montgomery, AL	110
Nashville, TN	112
Nashville, TN	114
New Orleans, LA	116
New York City, NY	118
Newark, NJ	120
Norfolk, VA*	122
Oklahoma City, OK	124
Omaha, NE	126
Orlando, FL	128
Orlando, FL	130
Peoria, IL	132
Philadelphia, PA	134
Phoenix, AZ	136
Pittsburgh, PA	138
Portland, ME	140
Providence, RI	142
Raleigh, NC*	144
Richmond, VA	146
Rochester, NY	148
St. Paul, MN	150
St. Petersburg, FL	152
Salt Lake City, UT*	154
San Antonio, TX *	156
San Bernardino, CA	158
San Diego, CA	**160**
San Francisco, CA*	162
Santa Ana, CA	164
Santa Rosa, CA	166
Savannah, GA	168
Seattle, WA	170
Spokane, WA	172
Syracuse, NY*	**174**
Tacoma, WA*	176
Tucson, AZ	178
Waco, TX*	180
Washington, DC*	182
Wilmington, DE	184

* Not updated since 9/97

Sample Profile Form

CityMatCH Member Urban MCH Profile Form

List all that apply on the attached profile form.

PROFILE INDEX I

Urban Health Department MCH Efforts by Type of Initiative *

Women's Health

1 Preconception promotion
2 Family planning
3 Breast/cervical cancer

Perinatal Health

4 Prenatal care
5 Expanding maternity services
6 Home visiting
7 Low birthweight/infant mortality
8 Substance abuse prevention
9 Breastfeeding/nutrition/WIC

Child Health

10 Immunization
11 Early intervention/zero to three
12 EPSDT/screenings
13 Expanded child health services
14 Injury (including child abuse)
15 Lead poisoning
16 Children with special needs
17 School-linked/based services

Adolescent Health

18 School-linked/based services
19 Violence prevention/at risk
20 Teen pregnancy
21 Teen parenting

Other

22 Communicable diseases
23 Family violence
24 Dental programs

Improving Access to Care for Urban Children & Families

25 Overcoming cultural barriers
26 Reducing transportation barriers
27 Expanding private sector links
28 Clergy & health connections
29 Schools & health connections
30 One-stop shopping locations
31 Mobile clinics for outreach
32 Other outreach activities
33 Increasing social support
34 Case coordination
35 Increasing access to Medicaid

Strengthening Urban Public Health Systems for MCH

36 Staff training
37 Strategic planning
38 Reshaping urban MCH
39 Securing MCH assistance
40 Managed care initiatives
41 Building coalitions & partnerships
42 Building MCH data capacity
43 Immunization tracking/recall
44 Infant/child death review

Other (please specify):

a. ____________________________
b. ____________________________
c. ____________________________
d. ____________________________
e. ____________________________

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* As used in "Lessons Learned 1996: Profiles of Urban Health Department MCH Efforts"

Which *Essential MCH Functions* apply to the MCH activity profiled?
List all that apply on the attached profile form.

PROFILE INDEX II

Urban Health Department MCH Efforts by Essential MCH Functions *

Assess MCH Status

1 Develop tools standardizing data collection, analysis, reporting
2 Implement public MCH program client data systems
3 Analysis of demographics, economic status, behaviors, health status
4 Community perceptions of health problems/needs

Diagnose/Investigate Occurrence of Problems & Hazards

5 Tracking systems
6 Population surveys (BRFS, PRAMS, PedNSS, YRBS)
7 Environmental assessments
8 Maternal, fetal/infant, child death reviews

Promoting Positive Beliefs, Attitudes, Behaviors

9 Hotlines, print materials, media campaigns
10 Culturally appropriate health education materials/programs
11 Implement/support education services for special MCH problems
12 Assessment of provider reports regarding process and outcomes

Community Partnerships

13 Prepare, publish & distribute reports
14 Public advocacy for legislation & resources

Research/Demonstration Projects

15 Special studies
16 Development of models

Assess Community Priorities & Action Plans

17 Develop & promote MCH agenda & YR2000 National Objectives
18 Newsletters, convening focus groups, advisory committees, networks
19 Promote compatible, integrated service system initiatives

Promote, Enforce Laws, Regulations, Standards, Contracts (LRSC)

20 Consistent, coordinated policies across programs
21 MCH input in legislative base for health plans & standards
22 MCH legislative activity
23 Development, promulgation, review, updating LRSC
24 Certification & monitoring provider compliance
25 Professional license & certification process
26 Monitor MCO marketing practices
27 Ombudsman services

Assure Capacity/Competency of Public Health Work Force

28 Provide infrastructure/capacity for MCH functions
29 Staff training
30 Support of continuing education
31 Support of health plans/provider networks
32 Health care labor force analysis
33 Laboratory capacity

Link MCAH Population to Services

34 Provide outreach services
35 Transportation & other access-enabling services
36 Referral systems, resource directories, advertising, enrollment assistance
37 Monitor enrollment practices for ease of use
38 Identify high-risk/hard-to-reach populations & methods to serve them
39 Provide, arrange, administer direct services
40 Universal newborn screening programs
41 Detention settings, foster care, mental health facilities
42 Prior authorization for out-of-plan specialty services
43 Review process for ped LT care admissions, CSHCN home services
44 Managed Care model contracts & access issues
45 Pediatric risk adjustment methods & payment mechanisms
46 Identify alternative resources to expand system capacity

Evaluate Effectiveness, Accessibility, & Quality of MCH Services

47 Comparative analysis of HC delivery systems
48 Profiles of provider attitudes, knowledge & practices
49 Identify & report access barriers

Other (please specify):

a. ______________________________
b. ______________________________
c. ______________________________
d. ______________________________
e. ______________________________

---

* Source: Grason, H. And Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

1997 CityMatCH Urban MCH Profile

Health Department: ______________________ City/State: ______________
MCH Activity: ____
____
Contact Person: ______________________ Phone: (____) ____________
FAX: (____) ____________
E-Mail: ____________________

Is this activity (✔ all that apply):
☐ a new MCH effort?
☐ an update from a profile submitted in ________ (year)?
☐ being replicated in another community: ____________________ (where)?
☐ being replicated from another community: ____________________ (where)?

Help us index your profile. Use the categories on the instruction pages to list all that apply.

PROFILE INDEX I: Urban Health Department MCH Efforts by Type of Initiative

Which types of initiatives best describe your activity?
(Please transfer corresponding number(s) from instruction sheet.)

____ ____ ____
____ ____ ____
____ ____ ____

Other (please list):
____

PROFILE INDEX II: Urban Health Department MCH Efforts by Essential MCH Functions

Which types of initiatives best describe your activity?
(Please transfer corresponding number(s) from instruction sheet.)

____ ____ ____
____ ____ ____
____ ____ ____

Other (please list):
____

1. Please describe the activity (issues addressed, date started, etc.):

2. What are the expected results/outcomes of this activity? What outcomes measures are being used to evaluate this activity?

3. What are the major accomplishments to date of this activity?

4. What are the greatest barriers facing implementation?	How are these barriers being overcome?
●	●
●	●
●	●
●	●

5. What has been the role of your health department in planning, implementation and evaluation?

6. Who have been the health department's key partners/collaborators in this activity?

How is the activity funded?

☐ City/County/Local government funds
☐ General state funds
☐ MCH block grant funds
☐ SPRANS funds
☐ Private source(s): Please specify:
____
____

☐ 330 funds
☐ Other Federal funds
☐ Third party reimbursement (Medicaid, insurance)
☐ Other: Please specify:
____
____

Approximate annual budget: $____________________

8. What is the greatest lesson your health department has learned and can share with others about this activity?

Profile Index I

1998 Urban Health Department MCH Efforts

By type of initiative

Target MCH Populations

		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
	Page	Preconception Promotion	Family Planning	Breast/cervical cancer	Prenatal Care	Expanding maternity services	Home visiting	Low birthweight/infant mortality	Substance abuse prevention	Breastfeeding/nutrition/WIC	Immunization	Early intervention/zero to three	EPSDT/screenings	Expanded child health services	Injury (including child abuse)	Lead poisoning	Children with special needs	School-linked/based services	School-linked/based services	Violence prevention/at risk	Teen pregnancy	Teen parenting	Communicable diseases	Family Violence	Dental Programs
State / City		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Akron, OH	20										■														
Albuquerque, NM	22				■																				
Anchorage, AK	24				■	■	■	■													■				
Austin, TX	26								■																
Baltimore, MD	28									■															
Berkeley, CA	30																			■				■	
Birmingham, AL	32																	■							■
Boise, ID	34										■														
Boston, MA	36				■	■		■	■																
Chicago, IL	38																				■	■			
Cleveland, OH	40							■																	
Columbus, OH	42																	■	■						
Colorado Springs,	44			■			■																		
Corpus Christi, TX	46		■		■										■						■	■			
Dallas, TX	48							■			■	■	■	■		■									
Dayton, OH	50													■											
Denver, CO	52											■		■			■								
Detroit, MI	54										■	■		■											
Durham, NC	56							■							■										
El Paso, TX	58										■														
Englewood, CO	60								■						■									■	
Evansville, IN	62										■			■									■		
Fort Worth, TX	64											■	■							■					
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Gary, IN	68										■		■	■	■	■									■
Grand Rapids, MI	70														■										
Greensboro, NC	72													■											
Hartford, CT	74	■	■		■	■	■	■	■	■						■				■	■	■	■	■	■
Honolulu, HI	76				■																				
Indianapolis, IN	78						■	■																	
Jackson, MS	80																								
Kansas City, MO	82	■	■			■															■	■			
Knoxville, TN	84		■																				■		
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Little Rock, AR	92										■														
Long Beach, CA	94				■	■																			
Louisville, KY	96																				■				
Madison, WI	98																								
Miami, FL	100			■																					
Milwaukee, WI	102													■				■	■						

Profile Index I

1998 Urban Health Department MCH Efforts

By type of initiative

	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families											Strengthening Urban Public Health Systems for MCH									Other				
	Overcoming cultural barriers	Reducing transportation barriers	Expanding private sector links	Clergy and health connections	School and health connections	One-stop shopping locations	Mobile clinics for outreach	Other outreach activities	Increasing social support	Case coordination	Increasing access to Medicaid	Staff training	Strategic planning	Reshaping urban MCH	Securing MCH assistance	Managed care initiatives	Building coalitions/partnerships	Building MCH data capacity	Immunization tracking/recall	Infant/child death review	Other	Other	Other	Other	Other
State/ City	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Akron, OH																	■		■						
Albuquerque, NM			■								■	■	■			■	■								
Anchorage, AK												■					■								
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Columbus, OH					■							■					■								
Colorado Springs, CO			■				■	■				■	■				■								
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Milwaukee, WI			■		■												■								

Profile Index I

1998 Urban Health Department MCH Efforts

By type of initiative

		Target MCH Populations																							
		Women's Health			Perinatal Health						Child Health								Adolescent Health				Other		
	Page	Preconception Promotion	Family Planning	Breast/cervical cancer	Prenatal Care	Expanding maternity services	Home visiting	Low birthweight/infant mortality	Substance abuse prevention	Breastfeeding/nutrition/WIC	Immunization	Early intervention/zero to three	EPSDT/screenings	Expanded child health services	Injury (including child abuse)	Lead poisoning	Children with special needs	School-linked/based services	School-linked/based services	Violence prevention/at risk	Teen pregnancy	Teen parenting	Communicable diseases	Family Violence	Dental Programs
State / City		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Minneapolis, MN	104																								
Missoula, MT	106												■												
Modesto, CA	108																	■			■				
Montgomery, AL	110																								
Nashville, TN	112																								
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New Orleans, LA	116										■														
New York, NY	118													■				■							
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Norfolk, VA	122													■	■		■								
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Orlando, FL	128										■								■						
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Waco, TX	180										■												■		
Washington, DC	182																								
Wilmington, DE	184																								

Profile Index I	Urban MCH Approaches																								
	Improving Access to Care for Urban Children and Families											Strengthening Urban Public Health Systems for MCH									Other				
1998 Urban Health Department MCH Efforts By type of initiative	Overcoming cultural barriers	Reducing transportation barriers	Expanding private sector links	Clergy and health connections	School and health connections	One-stop shopping locations	Mobile clinics for outreach	Other outreach activities	Increasing social support	Case coordination	Increasing access to Medicaid	Staff training	Strategic planning	Reshaping urban MCH	Securing MCH assistance	Managed care initiatives	Building coalitions/partnerships	Building MCH data capacity	Immunization tracking/recall	Infant/child death review	Other	Other	Other	Other	Other
State/ City	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
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Wilmington, DE																					■				

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Profile Index II

1998
Urban Health Department MCH Efforts

By essential MCH functions

		Access MCH Status				Diagnose/ Investigate Occurrence of Problems and Hazards				Promoting Positive Beliefs, Attitudes and Behaviors				Community Partnerships		Research/ Demo Project		Assess Community Priorities and Action Plans			Promote, Enforce Laws, Regulations, Standards, Contracts, (LRSC)			
	Page	Tools for data collection, analysis, reporting	MCH program client systems	Analysis of demographics, health systems, etc	Tracking systems	Population surveys	Environmental assessment	Maternal, fetal/infant, child death reviews	Hotlines, print materials, media campaigns	Culturally appropriate health education	Services for special MCH problems	Assess provider reports on outcomes	Prepare, publish, and distribute reports	Public advocacy for legislation and resources	Special studies	Development of models	Promote MCH agenda/Year 2000 Objectives	Newsletters, focus groups, advisory comm.	Integrated service system initiatives	Consistent, coordinated policies	MCH input in legislative base for health plans	MCH legislative activity	Develop, promulgate, review, update LRSC	Certification, monitoring provider compliance
State City		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Akron, OH	20																							
Albuquerque, NM	22	■			■				■															
Anchorage, AK	24																							
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Dallas, TX	48			■					■	■	■						■		■					
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Greensboro, NC	72																							
Hartford, CT	74							■		■														
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Miami, FL	100																							
Milwaukee, WI	102	■		■												■		■	■	■				

* Grason, H. and Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," John Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD
CityMatCH Lessons Learned 1997—pg 14

Profile Index II	**Enforce Laws, Regulations (Cont.)**			**Assure Capacity/ Competency of Public Health Workforce**						**Link MCH Population to Services**													**Evaluate Accessibility and Quality of Services**		
1998 Urban Health Department MCH Efforts By essential MCH functions	Professional license and Certification process	Monitor MCO marketing practices	Ombudsman services	Infrastructure/capacity for MCH functions	Staff training	Support for continuing education	Support of health plans/provider networks	Health care labor force analysis	Laboratory capacity	Provide outreach services	Transportation and access-enabling services	Referral systems, enrollment assistance etc	Monitor enrollment practices for ease of use	Identify high-risk/hard-to-reach populations	Provide, arrange, and administer direct services	Universal newborn screening programs	Detention setting, foster care, mental health	Prior authorization for specialty services	Review process pediatric LT, CSHCN services	Managed Care model contracts	Pediatric risk adjustment methods and payment	Identify resources to expand system capacity	Comparative analysis of HC delivery systems	Profiles of provider attitudes, knowledge, etc	Identify and report access barriers
State/ City	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48
Akron, OH										■				■	■										
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* Grason, H. and Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," John Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Profile Index II

1998 Urban Health Department MCH Efforts

By essential MCH functions

		Access MCH Status				Diagnose/ Investigate Occurrence of Problems and Hazards				Promoting Positive Beliefs, Attitudes and Behaviors				Community Partnerships		Research/ Demo Project		Assess Community Priorities and Action Plans			Promote, Enforce Laws, Regulations, Standards, Contracts, (LRSC)			
	Page	Tools for data collection, analysis, reporting	MCH program client systems	Analysis of demographics, health systems, etc	Tracking systems	Population surveys	Environmental assessment	Maternal, fetal/infant, child death reviews	Hotlines, print materials, media campaigns	Culturally appropriate health education	Services for special MCH problems	Assess provider reports on outcomes	Prepare, publish, and distribute reports	Public advocacy for legislation and resource*	Special studies	Development of models	Promote MCH agenda/Year 2000 Objective*	Newsletters, focus groups, advisory comm	Integrated service system initiatives	Consistent, coordinated policies	MCH input in legislative base for health pla*	MCH legislative activity	Develop, promulgate, review, update LRSC	Certification, monitoring provider complian*
State City		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Minneapolis, MN	104			■									■	■					■	■				
Missoula, MT	106															■			■	■				
Modesto, CA	108									■	■							■						
Montgomery, AL	110																							
Nashville, TN	112	■						■					■											
Nashville, TN	114																							
New Orleans, LA	116								■	■	■						■							
New York, NY	118								■		■							■						
Newark, NJ	120	■							■	■	■			■					■	■				
Norfolk, VA	122										■						■							
Oklahoma City, OK	124	■		■			■			■	■		■	■					■	■				
Omaha, NE	126															■					■			
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Orlando, FL	130																							
Peoria, IL	132			■						■	■			■		■			■					
Philadelphia, PA	134								■	■	■					■								
Phoenix, AZ	136									■			■						■					
Pittsburgh, PA	138		■	■						■						■			■	■				
Portland, ME	140				■											■								
Providence, RI	142															■			■					
Raleigh, NC	144								■	■								■	■					
Richmond, VA	146	■	■					■	■	■						■		■	■					
Rochester, NY	148	■	■													■			■					
St. Paul, MN	150								■	■														
St. Petersburg, FL	152										■													
Salt Lake City, UT	154									■														
San Antonio, TX	156																							
San Bernardino, CA	158												■				■			■				
San Diego, CA	160																							
San Francisco, CA	162								■		■		■	■				■						
Santa Anna, CA	164	■		■									■		■	■								
Santa Rosa, CA	166			■							■		■					■						
Savannah, GA	168									■	■		■											
Seattle, WA	170											■			■	■								
Spokane, WA	172	■			■																			
Syracuse, NY	174	■				■			■	■	■	■	■	■				■	■			■		
Tacoma, WA	176	■					■			■	■													
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Waco, TX	180	■			■					■			■					■						
Washington, DC	182																							
Wilmington, DE	184									■							■							

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CityMatCH Lessons Learned 1997—pg 16

Profile Index II	Enforce Laws, Regulations (Cont.)			Assure Capacity/ Competency of Public Health Workforce						Link MCH Population to Services													Evaluate Accessibility and Quality of Services		
1998 Urban Health Department MCH Efforts By essential MCH functions	Professional license and Certification process	Monitor MCO marketing practices	Ombudsman services	Infrastructure/capacity for MCH functions	Staff training	Support for continuing education	Support of health plans/provider networks	Health care labor force analysis	Laboratory capacity	Provide outreach services	Transportation and access-enabling services	Referral systems, enrollment assistance etc	Monitor enrollment practices for ease of use	Identify high-risk/hard-to-reach populations	Provide, arrange, and administer direct services	Universal newborn screening programs	Detention setting, foster care, mental health	Prior authorization for specialty services	Review process pediatric LT, CSHCN services	Managed Care model contracts	Pediatric risk adjustment methods and payment	Identify resources to expand system capacity	Comparative analysis of HC delivery systems	Profiles of provider attitudes, knowledge, etc.	Identify and report access barriers
State City	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48
Minneapolis, MN				■			■			■													■		
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Philadelphia, PA					■					■				■											
Phoenix, AZ																									
Pittsburgh, PA										■	■	■													
Portland, ME														■								■			
Providence, RI										■															
Raleigh, NC										■	■	■		■	■										
Richmond, VA				■	■				■		■	■		■	■							■			■
Rochester, NY				■										■	■										
St. Paul, MN							■																		
St. Petersburg, FL															■	■									
Salt Lake City, UT				■																		■			
San Antonio, TX					■	■																			
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Santa Rosa, CA																									
Savannah, GA					■					■				■	■										
Seattle, WA										■				■	■		■								
Spokane, WA										■															
Syracuse, NY	■				■	■	■			■	■	■	■	■	■			■		■	■	■		■	■
Tacoma, WA										■		■		■								■			
Tucson, AZ										■				■	■										■
Waco, TX						■					■			■	■										
Washington, DC																					■				
Wilmington, DE																									

* Grason, H. and Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," John Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

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1997
Successful
Urban
Health
Department
Initiatives
in
Maternal and Child
Health

Akron Health Department WIC/Immunization Coordinated Intervention Plan

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E-mail:

Replicated Elsewhere?
Yes. Three other Ohio County WIC Projects

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Laboratory capacity. Monitor enrollment practices for ease of use. Identify high-risk/hard-to-reach populations.	Immunization. Building coalitions & partnerships. Immunization tracking/recall.

Budget: $49,999

Funding Sources:

Other Federal funds.
Other: 93.268 Federal Domestic/CDC

Description:

In 1992, Ohio WIC services were enhanced to include immunization screening and referral for child aged five and under.

Program analysis revealed that WIC children continued to be under-immunized. The Ohio Department of Health-WIC and Immunization Divisions collaborated to pilot the WIC/IAP Coordinated Immunization Intervention Plan in four of seventy-six county WIC projects. The Summit County Pilot began in November 1996 and is conducted at one WIC clinic site. In the pilot program, Immunization Technicians focus on children under three years of age.

The objective is to increase Immunization Series Completion rates among WIC children under two years of age from forty-four percent to at least ninety percent, and to develop strategies that can be replicated in WIC clinics across the state.

Parents are asked to bring their children's immunization records to all WIC appointments. Immunization data is entered into the WIC Immunization Enhancement Program which prints a document ("Forecast") showing whether the child is up-to-date or past due and when the next immunization is due. WIC staff review this document with the parent and refer past due children to area immunization providers.

Families of children who are past due receive education regarding the importance of immunizations, a list of area immunization providers, referral and follow-up. Families who do not present immunization records are asked to bring them in or mail the records to the technicians, or if they have lost the records, to sign a Release of Information Form. The technicians then obtain the records from the families' health care provider. Follow-up includes making appointments and phone or mail appointment reminders.

Objectives:

WIC children will complete the Basic Series by age two (4 DTP/DTaP, 4 HIB, 3 Polio, 3 Hepatitis B, 1 MMR and 1 Varicella).

Role of Local Health Department:

As WIC Grantee for Summit County, the Akron Health Department is the parent agency.

Barriers Encountered:	Strategies to Overcome:
All physicians do not follow CDC/ACIP guidelines which results in missed opportunities, confusion and frustration for staff and families. Confidentiality issues. Forecast Module records immunizations as past due if child received an immunization before the recommended time period.	Forecast Module is being redesigned. WIC and Immunization System Programs are being combined.

Key Partners/ Collaborators:

Ohio Department of Health WIC and Immunization Divisions, Ohio Department of Health Child and Family Services.

Accomplishments:

Immunization rates have increased by 12%. The number of participants bringing immunization records to clinic has increased. The number of children screened per month increased from 185 in November '96 to 559 in July '97.

Lessons Learned:

Most area immunization providers will cooperate and support initiatives such as this. Several now call WIC for immunization records. Families are more compliant when they believe that providers care about them. They ask the technicians name and call them specifically to let them know that they followed through with an immunization appointment. They also ask for the technicians by name when they come to WIC or immunization appointments at the pilot site.

Helping Public Health's Medicaid Clients Transition to Managed Care

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Develop tools standardizing data collection, analysis, reporting Provide infrastructure/capacity for MCH functions. Review process for ped LT care admissions, CSHCN home services. Community perceptions or health problems/needs. Transportation & other access-enabling services. Profiles of provider attitudes, knowledge & practices. Maternal, fetal/infant, child death reviews. Referral systems, resource directories, advertising.	Prenatal care. Staff training. Building coalitions & partnerships. Expanding private sector links. Increasing access to Medicaid. Managed care initiatives.

Funding Sources:

Budget: Not reported.

Public Health involvement is funded through state general funds.

Description:

District 1 developed a plan to educate staff concerning state government's plan to implement Medicaid managed care so that Medicaid clients visiting Public Health offices could use Public Health as a resource. Educational focus was on the nature of Medicaid, eligible populations, implementation dates, anticipated roles of local Public Health staff, HMO enrollment process, and important deadlines.

This has been accomplished by:

1. A District wide 1 day training in Medicaid basics, conducted by the DOH Medical Director, Public Health Division Director, District Director and Human Services staff in late 1996. 2. Formation of a network of staff from local offices who participate in a monthly conference call with the District Director and District Health Officer to do updates on issues for clients transitioning to managed care. 3. Development of a tracking form by the Health Promotion epidemiologist which allows local offices to track client reports of problems with access to Medicaid managed care services as well as problem resolution. 4. Public Health staff attendance at community enrollment fairs to meet HMO, Advocacy Group representatives and Medicaid clients.

Objectives:

We anticipated a smooth transition to managed care for Medicaid clients of Public Health offices. Clients will utilize as much choice as possible in choosing an HMO and a medical provider. There will be an increased understanding by Public Health staff of Medicaid basics and ways to help clients. There will be renewed attention to presumptive eligibility determination.

Role of Local Health Department:

Planning: See overview. Implementation: There has been education of all Public Health workers about the Medicaid Managed Care process. Public Health staff have assisted Medicaid clients in local offices to understand their ability to choose an HMO, to determine their physician's membership in a given HMO and the paperwork technicalities involved. Evaluation: An evaluation was conducted at the close of the staff training. Minutes of monthly conference calls are kept. An analysis of issues on tracking sheets is being initiated.

Barriers Encountered:	**Strategies to Overcome:**
Medicaid Managed Care was implemented very quickly. There was a high level of staff uncertainty that managed care would be in the best interest of the clients. Changes continue frequently.	Monthly district-wide conference calls to exchange updates and address staff concerns are being used. Materials, including New Mexico Human Services Department newsletters and advisories from the District Director are being circulated.

Key Partners/ Collaborators:

New Mexico Human Services Department staff at the state, county and local levels have been key partners. Also, HMO representatives are now negotiating with the District about how to partner in service delivery.

Accomplishments:

1. The Public Health workforce feels prepared to assist clients to transition into managed care. 2. Public health offices have been a resource for Medicaid clients in the enrollment process. 3. There is a better understanding of their advocacy role.

Lessons Learned:

Local health office staff training has been essential to their feeling prepared to help clients meet these changes.

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Healthy Mother Healthy Baby

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Fax: (907) 343-6564
E-mail:

Replicated Elsewhere?
Yes. Sometime this Fall in Palmer, AK

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Laboratory capacity. Transportation & other access-enabling services. Monitor enrollment practices for ease of use. Identify high-risk/hard-to-reach populations.	Prenatal care. Expanding maternity services. Home visiting. Low birthweight/infant mortality. Substance abuse prevention. Breastfeeding/nutrition/WIC. Teen pregnancy.

Funding Sources:

Budget: $150,000

The State of Alaska Medicaid Services has provided the Municipality of Anchorage with grant funding of $150,000 to accomplish the contact, case management and outreach of the Healthy Mother Healthy Baby program.

Description:

Healthy Mother Healthy Baby is a home visiting program which focuses on the 21 and younger pregnant female. The teens are contacted prenatally and offered home visiting services that include: nutrition education and referrals to WIC, fetal growth and development, labor and delivery information including referrals to providers, support with social and emotional changes and needs, and linkage with public assistance. The home visiting does not end with the birth of their child but continues to support the development of positive parenting patterns.

The program started in July of 1993 with outreach to all women using Pregnant Women's Medicaid. The current program with the emphasis on teens started in July of 1996.

Objectives:

We expect to have earlier contact with pregnant teens than was previously possible. We believe in the benefits of early prenatal care and its relationship to the birth of healthy babies. Through early contact we can assist her linkage to providers, WIC, transportation and educational options. Public Health nurses assist her mental transition from child to parent as they work with her to begin a relationship with her fetus using pictures, growth and development information, and encouraging her to begin to notice fetal movements and patterns.

Evaluation of our program is accomplished in two ways. With the monthly Medicaid printout we have access to actual numbers of individuals contacted. We maintain numbers to show outreach efforts per teen, cumulative total of outreach attempts, and the number of refusals or acceptances. Our second evaluation tool is the use of feedback postcards which are sent to the teens by the outreach worker. The postcards evaluate the teens experience with the public health nurse and if they would recommend the program to a friend.

Role of Local Health Department:

Our health department has been contracted to do most of the planning, implementation and evaluation. The program supervisor and outreach worker plan the outreach schedule, accomplish most of the outreach, and implement the program. The outreach worker completes the initial contacts, intake of client referrals, and outcomes. We join with the health department's staff of public health nurses to provide the home visits.

Barriers Encountered:	Strategies to Overcome:
Teens often delay acceptance of the pregnancy, entrance into prenatal care and filing for public assistance. Teens are extremely mobile and even more difficult to locate if they do not have a stable home location. We have also found that providers are irregular in their referrals of teens.	We do receive a monthly printout of all the teens who have filed for Pregnant Women's Medicaid. Using this list we attempt phone and letter contact with each young woman. We have heightened our community exposure by helping to chair forums which address teen issues, and working with school nurses and educators. We continue poster and personal outreach to agencies, malls, retail stores, and coffee shops. Our posters, with their handy tear away cards, are visible throughout Anchorage in places that range from teen hangouts to supportive churches. Our outreach focus this coming year will be toward providers and increasing their referrals and collaboration with the public health nurse.

Key Partners/ Collaborators:

We have collaborated very closely with many different agencies and providers. A list of these collaborators include: Municipality of Anchorage's Maternal and Child Health Section and Family Planning Clinic, WIC, Prenatal Care II, Head Start, South central Foundation, Youth Resource Center, Crisis Pregnancy Center, Providence Memorial Hospital, Columbia Regional Hospital, the Anchorage School District, Medicaid Eligibility technicians, Department of Family and Youth Services, Anchorage Neighborhood Health Center and numerous individual providers/clinics.

Accomplishments:

We have experienced a dramatic increase in the public's awareness of programs for pregnant and parenting teens. We have swung our outreach lasso wide to rope in the alternative program high schools, providers and agencies who work with pregnant teens, and we walk the downtown transit area talking with homeless teens about various services available to them.

Lessons Learned:

We have learned that even when you offer a free, client centered service they may still refuse or be difficult to locate. We have fine tuned our ability to locate which agencies, providers, or services are likely to be sought by pregnant teens and then we work very hard to align ourselves with these programs. We have also learned that these agencies must be outreached to maintain their support and channeling of referrals.

Women and Substance Use: Improving Services

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E-mail: KarenHay@aol.com

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:

Culturally appropriate health education materials/programs.
Provide infrastructure/capacity for MCH functions.
Monitor enrollment practices for ease of use.
Implement/support education services for special MCH problems.
Staff training.
Comparative analysis of HC delivery systems.
Newsletters, convening focus groups, advisory committees, networks.
Transportation & other access-enabling services.

MCH Initiatives:

Substance abuse prevention.
Building coalitions & partnerships.
Expanding private sector links.
Staff training.

Funding Sources:

Budget: $25,000

General state funds.

Description:

The use and abuse of potentially harmful substance has remained an on-going issue affecting the health and well-being of families. Unfortunately, intervention typically occurs only when the problem has reached the point of crisis and involves the criminal justice system or child protective services. In order to intervene at earlier points in the course of substance abuse and dependency, training is necessary for staff to assist them in recognizing signs of substance use problems and to aid them in developing the skills needed to intervene effectively. To address the training needs of Department staff, a training series was developed and implemented.
Activities conducted:
a) Women and Substance Use: Improving Services - Part I. One-day workshop focusing on sensitivity issues associated with pregnant and parenting substance abusing women, basic information about the addiction process and treatment; and community resources for substance abusing and dependent women. Because of the interest in the training a repeat offering was conducted. Dates: January 7, 1997 and March 5, 1997.
b) Women and Substance Use: Improving Services - Part II. June 20, 1997
c) Part III - Ongoing workgroup meetings to sustain and extend knowledge and effectiveness (to begin Aug. or Sept. 1997).

Objectives:

Participants are expected to gain greater awareness of their emotional responses to substance abusing pregnant and parenting women. They are expected to feel more comfortable and effective at screening for and addressing substance use-related issues; they will have a greater understanding of the addiction process; and will ave greater familiarity with community resources that serve substance abusing women. Ongoing linkages between the Health and Human Services Department and community Substance Abuse Treatment providers will be established. Measures used to evaluate outcomes of the activities: 1. The substance Abuse Training Questionnaire (SATQ) was developed and used as Pre- and Post-test measures for the three training events. This 35-item measure was developed as a means of identifying pre-conceived perspectives that community health and human services workers carry with them as they encounter women who use and abuse substances. The measure was administered prior to the training and provided information that was used in tailoring some of the training components. It provided information as to what impact the training had on the element or issue that each individual SATQ item addressed. 2. Evaluation forms with items addressing the extent to which training objectives were achieved were used at the conclusion of each training event.

Role of Local Health Department:

Initially the Texas Department of Health had a lead role in the funding, planning, implementation and some of the evaluation of the training activities. The role of the ATCHHSD has increased over the course of the year. Currently this department has full responsibility for all facets of the activity.

Barriers Encountered:	Strategies to Overcome:
Time and staff requirements to do all the coordination activities for the training. Funding for training costs. Sustaining and building upon concepts conveyed in the training. Lack of community linkages and resources for substance abusing women and their children.	Allow sufficient time between activities to get all work done. Tap all resources. Private substance abuse provider donations, TX Dept of Health We are planning to implement the ongoing substance abuse workgroup We are working on community planning activities for substance abuse and continuing to develop relationships with community providers of substance abuse services.

Key Partners/ Collaborators:

The Texas Department of Health provided funding and initial planning and implementation support. Community Providers: Austin Family House, CARE Program of ATCMHMR, and AWARE (University YWCA) provided staff who participated in planning activities and presented key segments of the training. Phoenix House Council and Austin Recovery Center also provided staff to participate in a provider panel. Charter Behavioral Health System of Austin provided funds for refreshments for the initial training and provided training site and refreshments for the second training.

Accomplishments:

Approximately 100 Department staff attended one or more of the training activities to date. The response to the activities has been very positive. Ten staff members and three community substance abuse providers have expressed interest in participating in the ongoing study group that is yet to be implemented. Findings from the SATQ show that the training impacted the issues addressed in the training. In particular, following the initial training, participants indicated increased knowledge of alcohol and drug abuse and addiction, perception of more community resources available, improvement in interviewing skills and in comfort in asking clients about their substance use. Greater sensitivity to the issues of substance abusing women was also indicated. Ratings of the training staff and training objectives were consistently very positive. Findings from the SATQ indicated that over half of the training participants had family members or close friends with substance use problems or had substance use problems themselves.

Lessons Learned:

In general, training activities for Department staff are critically needed and serve as opportunities for communication among staff who rarely cross paths as well as for providers in other community service sectors to become personally acquainted.

More specifically, in regard to women and substance use, in our city/county health and human services system, training to better understand the issues faced by women with substance abuse problems is a great need. Anger and judgmental attitudes are common and serve as barriers to identification and referral. The result is missed opportunities to intervene before the impact to the women themselves and to their children progresses to the point of devastating consequences and criminal justice and child protective services interventions. Training that includes information, sensitivity awareness activities, skill building components, and knowledge transfer is needed to improve services. In addition, without activities that bring together staff from health and human services with staff from community substance abuse programs, referral efforts are less likely to be effective. Sustaining and extending staff knowledge, understanding, and skills beyond the training events is a challenge.

WIC Hotline and Referral Center

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E-mail:

Replicated Elsewhere?
Yes. Various Maryland Counties

Updated Profile?

Essential MCH Functions:*

Develop tools standardizing data collection, analysis, reporting
Maternal, fetal/infant, child death reviews.
Hotlines, print materials, media campaigns.
Development of models.
Newsletters, convening focus groups, advisory committees, networks.
Provide infrastructure/capacity for MCH functions.
Transportation & other access-enabling services.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.

MCH Initiatives:

Breastfeeding/nutrition/WIC.
Expanding private sector links.
Clergy & health connections.
School & health connections.
Other outreach activities.
Increasing social support.
Building coalitions & partnerships.
Immunization tracking/recall.

Funding Sources:

Budget: $275,000

Other Federal funds.

Description:

The Hotline and Referral Center is the customer service and public relations unit for Baltimore City WIC Program which was initiated in 1994 through a special grant from the Maryland State WIC Program. The Center has three objectives: (1) to provide a central location where clients can obtain information about eligibility and selected benefits of the program or request appointments for selected WIC clinics; (2) to link clients to various health, social and other service organizations; (3) to coordinate outreach activities, including but not limited to advertising, increasing and/or maintaining participants, as well as, networking with and providing literature or presentations to hundreds of related programs and health care providers. The WIC Hotline and Referral Center is the first of its kind in the State of Maryland. It is staffed by Baltimore City Employees who provide assistance to six city WIC Programs that together serve about 25,000 clients. The structure and the commitment of the staff help to accomplish a wide variety of goals. The hotline has a database which has been programmed to generate a number of reports and analyses. The database has a referral component which stores information about hundreds of agencies to where WIC clients may be linked. Planning for outreach activities is accomplished with reports and other information obtained from the database.

Objectives:

Expected results of this activity are to increase awareness about WIC, educate the public about the benefits of the program, promote strategies for reaching high risk populations and to help participants gain access to other valuable services. The Hotline tracking and scheduling database is designed to assist with measuring success in scheduling clients and increasing participation. The database also generates reports which indicate from what agencies high risk participants are being referred (i.e. hospitals, clinics, medical assistance, prenatal programs). The computerized telephone equipment generates reports of all outgoing and incoming calls such that external linkages can be measured.

Role of Local Health Department:

The Baltimore City Health Department (BCHD) has been involved in every element of this activity in partnership with the state

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WIC program. BCHD is functioning as the pilot jurisdiction for the state. BCHD WIC staff wrote the proposal and had input into the design of the computer program. BCHD had hired staff and purchased the necessary equipment, furniture and supplies. BCHD has tested and evaluated the software and provided feedback for changes to the tracking system. Several reports are generated by BCHD (with technical assistance from the state WIC program) from the tracking system for evaluation purposes.

Barriers Encountered:	**Strategies to Overcome:**
Lack of fully computerize tracking system.	Design and install upgrades for computerized tracking system.
Outdated directories and resource listings.	Quarterly contact with key organizations to obtain new information about service organizations.
Using additional technology to conduct reminder calls regarding appointments so that the system performs optimally.	Through the purchase of an automated reminder system.
Inability to handle the volume of calls related to site scheduling.	By seeking funds to hire additional personnel to handle calls and through the purchase of an automated distribution system.

Key Partners/ Collaborators:

Key partners/collaborators in this effort include the following: Maryland State WIC program staff, Baltimore City Health Department WIC program staff, Baltimore City Immunization program staff, Medicaid managed care organizations, 5 other city WIC programs, Department of Social Services, many community-based organizations.

Accomplishments:

The major accomplishment to date has been the strengthening of relationships with other programs for the purpose of increasing participation within the high risk, hard to reach population. In addition, the networking has helped link participants to other health and social services for which they may qualify. The original database was redesigned to increase efficiency and to generate improved reports.

Lessons Learned:

The greatest lesson learned is that quality of service and disseminating accurate and adequate information play a key role in maintaining satisfied customers. It increases the cooperation and enthusiasm of key collaborators. Conducting follow-up with clients gives a personal touch and makes people feel important.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Youth First/Lideres Jovenes

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Maternal, fetal/infant, child death reviews. Hotlines, print materials, media campaigns.	Violence prevention/at risk. School & health connections. Family violence. Overcoming cultural barriers.

Funding Sources:

Budget: $12,705

Private source(s). East Bay Public Safety Corridor Partnership

Description:

Youth First/Lideres Jovenes is a summer youth employment and training program sponsored by the Maternal and Child and Adolescent Health Department, Domestic Violence Section. Twenty (20) youth were trained to participate as leaders in school and community based domestic violence prevention programs. They collaborated with the Berkeley Community Media to create a bi-lingual video in Spanish for a youth audience.

The curriculum used was a unique combination of other programs to teach youth about the root causes of violence including teen dating violence, conflict resolution skills and creating healthy relationships. After the training the youth participated in the video production from the pre-production phase, planning, production and editing the final product. Finally, they produced a program about dating violence which aired on the local Berkeley Cable Channel 25 where they discussed the experience.

Objectives:

Develop a core group of youth committed to participating in peer education efforts at their school, church, or other community group in order to reduce relationship violence; develop youth leadership skills, promote communication and cooperation among youth; provide opportunities to build alliances with adults who will support the violence prevention work already begun by these young people; provide young people the opportunity to practice valuing differences, offer mutual support to each other and encourage collective responsibility among themselves; and produce a video reflecting various forms of violence to be shown on cable television. Evaluation of measures to be used are questionnaires completed by the participants and instructors, attendance records, response to the showing of the video in the Berkeley community.

Role of Local Health Department:

The coordinator of the Domestic Violence Prevention Partnership, a part of the Maternal, Child and Adolescent Health section of the Public Health Department was responsible for the planning, implementation and evaluation of this program. Evaluation is on-going. It involved questionnaires from the participants, yet to be reviewed. As the video is shown throughout the city and with the participating agencies feedback will be elicited. The governing bodies of the city will also be a part of this evaluation, as their input will be obtained.

Barriers Encountered:	Strategies to Overcome:
Flow of funding was very slow--actually getting the funds from the granting agency, then the distribution of the funds from the city to the agencies working on the project. Meanwhile the participants needed to receive their pay in a professional manner. Graffiti damage to school premises utilized for the program.	Resolution of the funding barrier is difficult. If a program is a time limited (e.g. summer) activity, requiring all work to be completed by a specific time, there needs to be a fast flow of funds. Therefore, the conduit for such a grant should not be a governmental agency, but an efficient, not for profit organization. In our case it was overcome by having a benefactor front the payroll until such a time as the grant monies could be processed and the benefactor repaid. Resolution obtained by having all the students who had access to the facility (boys bathroom) help to clean it up before they would be paid. It taught the kids community responsibility.

Key Partners/ Collaborators:

The participation of the Domestic Violence Prevention Partnership working in the City included Berkeley High School Health Center, ADELANTE, Inc., St. Joseph the Worker Church and School, East Bay Asian Youth Center, and the local women's shelter (Women's Refuge) to recruit the students, provide the space for the program and act as a fiscal conduit. In addition Berkeley Community Media helped to provide the space and the video instructor for the program.

Accomplishments:

The Video has been produced and is edited. All 20 of the original participants completed the program. The video is available for showing. It has been shown several times on the high school campus by peer educators.

Lessons Learned:

Working with youth towards a definitive product is invaluable. However, close guidance and lots of flexibility is required. A full time individual from MCAH was required. The most frustration came with the flow of funds for the project as described above. Asked if we would do it again, however, OF COURSE! The experience was invaluable. To maximize the outcome, continuity of personnel is critical.

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Portable Dental Sealant Program

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Fax: (205) 930-1448
E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Provide outreach services. Identify high-risk/hard-to-reach populations. Provide, arrange, administer direct services.	School-linked/based services. Dental programs.

Funding Sources:

Budget: $300,000

We are funded through local government funds and limited third party reimbursement (Medicaid).

Description:

In the mid-80's Dental Health Services of the Jefferson County Department of Health began a portable dental sealant program in which low income children in various schools of Jefferson county were afforded the opportunity of having dental sealants placed on all fully erupted, non-carious posterior permanent teeth. Schools that are targeted are those in which at least 75% of the student population are on free and reduced lunch. A $2.00 fee is assessed for the services, but waived if the parents cannot afford it. In this program, a child receives a dental exam, a toothbrush kit, and placement of sealants. They also receive, if prescribed by the dentist, a dental health education session and a topical fluoride treatment. After services have been performed the child receives a dental "report card" to take home to the parents which informs them of the findings of the dental exam and any preventive treatment that the child received. A referral number is provided for any child that does not have a regular dentist. Also, the report card contains patient satisfaction survey which the parent can complete and mail back (postage free) to Dental Health Services to allow us feedback.

Objectives:

With existing staffing patterns and schools targeted, it is expected that virtually every indigent child within Jefferson County will have the opportunity to have dental sealants placed on their teeth. As a result of this program, coupled with the fact that community water sources in Jefferson County are fluoridated, these children have the potential of remaining caries free. This program is being monitored by regular DMF (Decayed, Missing and Filled) surveys, which is a measure of decay rates and sealant retention surveys to insure those sealants that are placed are being retained.

Role of Local Health Department:

Except for consulting services, all planning, implementation and evaluation has been performed by staff within Dental Health Services.

Barriers Encountered:

Low participation rates among students have proven to be the most significant barrier encountered. In FY '97 only 53% of the students at participating schools took advantage of the program. One school had a participation rate as high as 81% while another had a participation rate as low as 31%.

Strategies to Overcome:

A consultant was hired to give input into increasing participation. We know that all the schools "WANT" our services, but some schools are more aggressive in getting their students to participate than others. We are looking at ways to boost interest not only among the students, but also among the school staff. We must also reach the parents. We hope to accomplish this through school mailings and attending PTA/PTO meetings.

Key Partners/ Collaborators:

We are fortunate in that we have always had the support of the Health Officer. Key personnel within Dental Health Services have been Dr. Tom Butts, Ms. Thelma Wesley (retired) and Ms. Natalie Williams.

Accomplishments:

Our surveys have shown a decrease in DMF rates for those children who have participated in this program as compared to those children who have not. In FY '97 approximately 8,000 sealants were placed on 2300 school children.

Lessons Learned:

We can make a difference in the oral health of the indigent children in Jefferson County. If we can boost our participation rates, with our funding and our staffing pattern, we have the potential of seeing that virtually every indigent child in Jefferson County has the opportunity of remaining caries free.

Idaho Volunteer Baby Track Program

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Fax: (208) 327-8500
E-mail: DWicklif@Phd4.state.id.us

Replicated Elsewhere?
Yes. Statewide in Idaho by Health Districts

Updated Profile?
Yes. 1996

Essential MCH Functions:	MCH Initiatives:
Community perceptions or health problems/needs. Maternal, fetal/infant, child death reviews Hotlines, print materials, media campaigns. Implement/support education services for special MCH problems.	Immunization.

Funding Sources:

Budget: $6,500

Other: CDC Immunization Grant

Description:

In April of 1996, CDC did a national survey and found Idaho was 50th in Immunizations. Last year we did a "Three Way Immunization Study" and found out that a personalized phone call to parents/guardians would bring results; their children received their immunizations. As a result of last year's study we developed a Volunteer Training Program for Idaho Baby Track.

Objectives:

Expected results are increased immunizations; decreased incidence of vaccine-preventable diseases. Idaho is currently the lowest state in immunizations. We rank 50th out of 50 states.

Role of Local Health Department:

We have facilitated the Idaho Baby Track training Program; mentoring volunteers, providing facilities for them to work, paying cost of phone calls, being all-around support for the volunteers.

Barriers Encountered:	Strategies to Overcome:
Training. Long distance calls. Spreading the word of "Babytrack" Volunteer Program. Reaching the public.	Consistent volunteer training. Calls made from Health Department. Utilizing nurses from Nursery Department at nearby hospitals to support program. Having the Governor's wife involved as a "Babytracker".

Key Partners/ Collaborators:

Hospitals, birthing and nursery departments, volunteers in Service to American volunteers, and their co-workers in RSVP programs.

Accomplishments:

More parents are getting their children immunized; however, it is too early to gauge results of our immunization and outreach program.

Lessons Learned:

Utilize retired people who want to be volunteers. The "personal touch" of a voice, rather than an answering machine, can bring results.

Only through a collaborative effort involving hospitals, volunteers and private providers can we raise Idaho's immunization rate.

Healthy Baby Second-Hand Smoke Study

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:*	MCH Initiatives:
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status. Population surveys (BRFS, PRAMS, PedNSS, YRBS). Hotlines, print materials, media campaigns. Culturally appropriate health education materials/programs. Assessment of provider reports regarding process and outcomes. Public advocacy for legislation & resources. Special studies. Provide infrastructure/capacity for MCH functions. Staff training. Laboratory capacity. Monitor enrollment practices for ease of use.	Prenatal care. Expanding maternity services. Low birthweight/infant mortality. Substance abuse prevention. Other outreach activities. Staff training. Building coalitions & partnerships.

Funding Sources:

Budget: $103,000

Private source(s): Robert Wood Johnson Foundation

Description:

The Healthy Baby Second-Hand Smoke Study represents a collaboration between the Boston Public Health Commission's Healthy Baby Program and the Dana-Farber Cancer Institute. This project is a research study designed to evaluate the impact of a novel motivational intervention on smoking during pregnancy and on household levels of environmental tobacco smoke (ETS). The intervention is designed to help smokers who are pregnant re-evaluate their decision to smoke, and to provide them with support and skills needed to quit smoking. In addition, the intervention is designed to reduce ETS levels in the home both during and after pregnancy.

Public health nurses in the Healthy Baby Program have been trained in motivational interviewing, a unique intervention style that has been found to be an effective strategy for impacting on risk behaviors. All participants in the intervention group receive this intervention in the context of the usual home visitation and outreach services provided by the Healthy Baby Program. The invention includes feedback about the levels of ETS found in the home and other information about the participant's risk status, as well as goal-setting and social support.

This collaborative project reaches a high-risk group of women, and intervenes on smoking in the context of a program that already addresses a variety of medical and social issues. In this regard, it is likely that women will be more interested in considering smoking cessation, and in taking steps to reduce their families' exposure to environmental tobacco smoke.

Objectives:

It is hypothesized that the intervention condition will lead to a greater rate of smoking cessation, quit attempts and decreased levels of ETS, compared to the usual care condition. The outcomes are being evaluated using biochemical verification (saliva cotinine) of self-reported smoking status, and passive monitoring of household nicotine levels.

Role of Local Health Department:

The health department has been very active in the planning and implementation of the grant. A nursing advisory committee has been established, and the nursing supervisors also actively deal with implementation issues. The study evaluation is being conducted by the DFCI, in collaboration with the health department.

Barriers Encountered:	Strategies to Overcome:
This client population is somewhat transient, and therefore very difficult to track over time. There are also competing priorities in the limited amount of time that nursing staff has with participants.	Substantial resources are being devoted to participant tracking. We are working closely with nurses to address their concerns about the focus on smoking and to provide them with skills needed to successfully complete the intervention.

Key Partners/ Collaborators:

Dr. Karen Emmons and her staff at the Dana-Farber Cancer Institute.

Accomplishments:

The study is still in progress and the outcomes are not yet available. Anecdotally, participants report a high level of satisfaction with the intervention.

Lessons Learned:

It takes a while to establish a relationship with a pregnant client that will give you substantive information regarding smoking behaviors.

Constant supportive long term follow-up is so important in changing women's smoking patterns and behaviors.

The importance of considering the total environment in supporting behavior changes regarding second hand smoke.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Male Responsibility Program

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Culturally appropriate health education materials/programs. Public advocacy for legislation & resources. Monitor enrollment practices for ease of use.	Teen pregnancy. Teen parenting.

Funding Sources:

Budget: $37,000

MCH block grant funds.
Other: Title X, CDBG

Description:

Programs designed to prevent adolescent pregnancy have been aimed almost exclusively at adolescent females, while the role of the male in pregnancy prevention has been largely ignored. The exclusion of men from family services has been evident in programs that pay for family planning services for women, and in delivery systems that do not truly welcome men who have the courage to seek family planning services.

This male responsibility program has used peer educators to reach other youth. The project is being implemented with youth in two high schools located in predominantly African-American communities in the City of Chicago. The percentage of persons under 24 years of age in the two selected communities represent 47.1% and 45.8% of their total population, in comparison with the Chicago rate of 37.5%. The group of adolescents and young adults are at high risk for sexually transmitted diseases and pregnancies. The percentages of births to teens in the two communities are similar: 32.4% of annual births in one, and 31.2% in the other. These are nearly twice the citywide rate of 18.8%. Teen mothers are at risk for a variety of health and social problems, including repeat pregnancies, school drop-out, and unemployment.

Objectives:

The purpose of the program to examine the outcomes if African-American male adolescent peer educators were trained to provide information that would promote positive participation by young men in reducing the incidence of sexually transmitted diseases, and the incidence of adolescent pregnancies. The program will also provide the peer educators with opportunities for community involvement in health promotion programs to enable them to acquire skills that may allow them to enter the world of work, or to make choices for continuing their education. **Outcome Measures: Change in knowledge** as measured by pre- and post-test results. **Behavior change** as measured by: statements of intentions to practice abstinence or to use condoms if they are sexually active; evidence that they have accepted condoms, and statements that they have used them; and statements that they have encouraged their girlfriends to use some form of birth control.

Role of Local Health Department:

The health department planned, implemented, and is currently evaluating the program. The department recruited and trained volunteers, and was in charge of all aspects of the program.

Barriers Encountered:	Strategies to Overcome:
Attrition of students. We wanted 4 from each school, but finished 3 + 4. Conflict with class schedules of peer educators. Schools on probation. This was not a high priority. Finding groups for peers to educate.	Recruited others Flexibility in scheduling Outreach to blocks and basketball courts

Key Partners/ Collaborators:

The chief collaborators in the study were the two high schools where the program is being implemented.

Accomplishments:

Seven young men aged 16-18 years were trained as peer educators. During this period, the health educator at one of the schools allowed the students to practice sharing information with students during regular class periods. During the summer, the peers provided sessions for mixed groups (average 15 students per group) who were attending summer school. According to the pre-and post-tests, peers and their target groups increased their knowledge of STD/HIV and pregnancy prevention. The students liked the program presented by the peers. Behavior change: Some of the peers were not, and continue to remain abstinent. The others say that they now use condoms. The peers distribute condoms to the students, and to their peers on the street and on the basketball court. These have been well accepted.

Lessons Learned:

Adolescent males are interested in receiving correct information about human sexuality.

Girls and boys said they enjoyed the classes. Some peer educators were more comfortable with the mixed groups than with others.

The coordinator of the project is an African-American male. His personality was a key element in the success of the program.

Boys appear to have more extra-curricular activities than girls, and this presents challenges for program planning.

On the other hand, the activities of boys is an asset that can be used effectively since it enhances their ability to reach groups not normally found in the classroom.

The peer educators felt proud of their new "roles as community experts", and the distributors of condoms.

Cleveland Healthy Family / Healthy Start Project's Medical Outreach Mobile Unit

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Replicated Elsewhere?
Yes. Chicago, Puerto Rico

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Ombudsman services. Monitor enrollment practices for ease of use. Identify high-risk/hard-to-reach populations.	Mobile clinics for outreach. Low birthweight/infant mortality.

Funding Sources:

Budget: $75, 985

Other Federal funds.
Other: City of Cleveland, General Funds

Description:

The Cleveland Healthy Family/Healthy Start Project's (HF/HS) Medical Outreach Mobile Unit (MOMobile), a 35 foot, fully contained mobile clinic made its debut in April, 1997.

The Unit provides medical screenings, pregnancy tests, counseling, risk assessments, and ongoing maternal and pediatric education in neighborhoods that historically have a higher than average infant mortality rate. The Unit's primary goal is to bring needed services to pregnant women and families with children under the age of one where lack of transportation or knowledge of available services may have been an inhibitor.

The Unit is scheduled to visit sixteen neighborhoods in the HF/HS Project area on a regular basis. The Unit is also scheduled to attend community/city wide events and neighborhood health fairs.

The MOMobile includes two exam rooms, an office and a waiting area with a TV/VCR for the showing of educational videotapes about prenatal and postnatal care. Additionally, the MOMobile is equipped with a washroom, microwave and refrigeration unit. The Unit is staffed by a full-time driver/coordinator and a nurse practitioner specializing in OB/GYN. Outreach Workers also accompany the MOMobile to enroll qualified clients, and counsel and assist women in applying for other needed health and social programs. Future plans include hiring a Medical Team Assistant to assist with patient flow and vital signs.

Objectives:

The expected results/outcomes of this activity for the enrollment of high-risk pregnant women into the HF/HS Project are: reduce infant mortality rates, engage pregnant women in early and continuous prenatal care, provide STD/HIV education/testing and administer age-appropriate immunizations.

Role of Local Health Department:

The Cleveland Department of Public Health has been instrumental in scheduling the Unit at community health fairs, marketing the Unit's services to the media and linking the Unit with other community resources.

Barriers Encountered:	Strategies to Overcome:
Bureaucracy	Mayor's support
Legislation / City Council	Assertive Project Director / Mayor's support
Selling the concept	Data supported the concept / assertiveness
Target population suspicious and reluctant to access Unit	Positive press

Key Partners/ Collaborators:

• HF/HS Consortium Builders and Community Organizers • HF/HS Coordinators and Outreach Workers • Cleveland Dept of Public Health, Division of Health • Cleveland Dept of Public Health, Division of Environment, Childhood Lead Poisoning Prevention Project • Neighborhood Centers Association • MetroHealth Medical Center • Cuyahoga County Dept of Human Services • Other Healthy Start sites (Dallas and Washington DC)

Accomplishments:

A heightened sense of public health awareness as demonstrated by the numerous requests for the MOMobile.

Statistics for the first five months of implementation (April - August 1997) Total Unit Contacts: 1,784, Total Services Rendered: 1,141, Total Pregnancy Tests administered: 52 with an estimated 15-20 high risk enrollments, Children Screened for High Lead Levels: 356, Adults Screened for STDs/HIV: 40, Children Received Immunizations: 20, Individuals Received Educational Health Services: 202, Individuals Screened for High Blood Pressure: 374, Individuals Screened for Glucose Levels: 55 and Referrals Made for Additional Medical/Social Services: 45

Lessons Learned:

There are individuals in the community who require important health services but due to their lack of mobility and other socioeconomic factors, services are unavailable to them. The MOMobile is a very effective tool to raise awareness of marginalized populations' lack of access to basic screening services.

"Building Healthy Life-Styles" Health Promotion of the Columbus Health Department

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Develop tools standardizing data collection, analysis, reporting Assessment of provider reports regarding process and outcomes. Special studies. Develop & promote MCH agenda & YR2000 National Objectives. Newsletters, convening focus groups, advisory committees, networks. Identify high-risk/hard-to-reach populations.	School-linked/based services. School-linked/based services. School & health connections. Staff training. Building coalitions & partnerships.

Funding Sources:

Budget: $159,000

Other: Preventative Health, Health Services Block Grant, Coordinated by Centers for Disease Control through Ohio Department of Health

Description:

Developed a partnership between an urban local health department and the school district food services aimed at improving healthy eating behaviors among school children while ensuring availability of healthy food choices. This partnership was established with the objectives of: 1) developing healthy alternative standardized recipes for replication to approximately 42,000 meal servings everyday; 2) facilitating introduction of new products in schools that are low in fat and promote consumption of fruits and vegetables; 3) training of food services staff; 4)facilitating USDA approved "Team Nutrition" approach in the schools; and 5)supplementing nutrition in classrooom and during school lunches.

Objectives:

The process evaluation utilized tools such as subtask completion checklists and records, maintenance of event logs, and qualitative ratings of services/products. Impact evaluation used a time series analysis of food consumption surveys of school children done at the beginning of the school year, after six months of the partnership and at the end of the school year. Our findings showed a base line improvement of 12% of fruit and vegetable consumption among the elementary children.

Role of Local Health Department:

The Columbus Health Department, (CHD) planned, implemented and evaluated the partnership with the CPSFSC. The CHD worked in cooperation with CPSFSC to develop additional insight and direction on how to meet our goals. In addition, CPSFSC provided the health department with opportunity to study elementary school children's food patterns for future menu modifications.

Barriers Encountered:	**Strategies to Overcome:**
Lack of cooperation and/or ownership of project. Lack of personnel-assistance. Budget cuts at the Columbus Production Center.	Discussion/collaboration among key players. Learned from past year experiences. Strategically planned for new approaches this school year.

Key Partners/ Collaborators:

Manoj Sharma - Health Promotion Supervisor
Angela H. Conigy - Registered Dietitian
Liane Egle - Director of Health Communications

Accomplishments:

A) Developed a Visual Food Item Acceptance Survey Form. This survey is used to assess food consumption. The survey results identify the popularity of food items as well as show consumption variances between elementary schools.

B) Early in the year we reintroduced sloppy joe to the elementary children. Although this recipe contained modifications, it still was well accepted with the children because of its good flavor and form. The modifications include a decrease in the ground meat and the addition of more onions, green peppers and dried rolled oats. Because we were able to increase the nutritional content and reduce the amount of fat in the product without losing taste, we experienced a favorable outcome. Therefore, the modified sloppy joe is now served routinely to the elementary children. This modified sloppy joe has now been re-named to "*So-Healthy Joe*".

C) Columbus Public School Food Service Center, (CPSFSC) currently provides the children, with baby carrots, cleaned and prepackaged. This heart healthy food is not popular with the elementary children. However, when we combined it with low-fat ranch dip the acceptance signficantly increased.

Lessons Learned:

Our food survey identified that elementary children's consumption of fruits and vegetables are low. The menu may meet the USDA Dietary Guidelines, however, results indicate fruit and vegatable consumption is far lower than expected. The CHD needs to continually work with the CPSFSC to modify the menus to increase fruit and vegetable consumption. That is an important lesson I learned while working with the CPSFSC.

Pikes Peak Breast Health Connection Project

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Maternal, fetal/infant, child death reviews. Implement/support education services for special MCH problems. Newsletters, convening focus groups, advisory committees, networks. Provide infrastructure/capacity for MCH functions. Laboratory capacity. Transportation & other access-enabling services. Profiles of provider attitudes, knowledge & practices.	Breast/cervical cancer. Home visiting. Expanding private sector links. Mobile clinics for outreach. Other outreach activities. Staff training. Building coalitions & partnerships.

Funding Sources:

Budget: $42,000

Susan G. Komen Foundation, CDC funded
Colorado Women's Cancer Control Initiative

Description:

In January 1996, we applied and received funds from our local Susan G. Komen Foundation, implementing a Department-wide campaign, to increase awareness of breast cancer and the need for early detection through mammography. All divisions and programs within our Department were incorporated in our outreach. Through cross discipline planning sessions we created innovative educational materials and outreach approaches. This included: Environmental Health, Nursing Division, Education and Prevention Programs, Drug and Alcohol Treatment Program, Vital Statistics, Child Abuse Prevention Project, Laboratory and Sexually Transmitted Disease Clinic.

In January 1997, we received additional Komen funding. Funding was expanded through our State Health Department with CDC funds (Colorado Women's Cancer Control Initiative). This additional funding enhanced our efforts to provide an in-depth marketing campaign which includes free breast health screening to women who meet financial guidelines. Our department spearheaded efforts to better understand various funding sources and client eligibility criteria to provide comprehensive and effective methods to increase mammograms with low income underserved women. Members of our Breast Health Connection Project include the following groups: the American Cancer Society, providers of mammograms, community health center and participation with local providers of screening services. Outreach was planned through local flu clinics and senior centers. Department staff received an in-service to update their knowledge and expand support for our department-wide breast caner awareness project. We provided two on-site mammogam screenings at local senior centers. Our primary strategy ws to enlist the support of family members and friends to encourage the women they know to get mammograms. Another strategy planned for 1997 is to educate clients in Department waiting areas through listed message boards and educational videos.

Objectives:

A 25% increase in clinical breast screening and mammograms to low income women ages 40 and older.

Role of Local Health Department:

We have worked collaboratively within the department and within our community to better serve low income women with inadequate access to services.

Barriers Encountered:	Strategies to Overcome:
Funded programs through the CDC focus 90% of their efforts to women 50 and older. However, new National Institues of Health and American Cancer Society guidelines strongly suggest the need to increase mammograms for women age 40 and older. We need to expand funding and services to women ages 40-49, without diminishing our efforts to reach women 50 and older who have a greater risk of breast cancer. Coordinating multiple programs and disciplines with large differences in knowledge, attitudes and motivation to implement an effective breast cancer awareness campaign.	Funding provided through our local Susan G. Komen Foundation has expanded outreach and screening services for women ages 40-49. We hope to increase Komen funding for this target population. We need to advocate for more federal funding to address this population and expand funding to reach the younger population. Involving programs and divisions in project planning is essential for department-wide "buy in" on health promotion projects. Give different divisions and programs a chance to explore how project implementation would best work within their department and program. Be patient, new projects and organizing health promotion efforts take a lot more time when you are involving the entire department.

Key Partners/ Collaborators:

American Cancer Society, Planned Parenthood, Penrad Imaging, Community Health Centers and local Senior Centers.

Accomplishments:

A successful department-wide Mother's Day card campaign implemented throughout the Department with over 10,000 cards distributed to clients.

15% increase in breast cancer screening and mammograms for low income women served by local clinics. Successful community partnership with a variety of agencies and funding partners working together to provide a more effective and seamless approach to breast cancer screening. This has resulted in two senior center mobile mammograms being administered to over 80 women. We also have a better understanding of breast cancer outreach and screening projects within our community.

Lessons Learned:

A multi-disciplinary, department-wide approach to breast cancer awareness is more of a challenge to plan and implement. It takes more time, skill and patience to get input and "buy-in" from all programs within a health department. However, it greatly increases outreach when you think beyond traditional disciplines to implement breast cancer awareness campaigns.

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To Your Health Women and Children/A Su Salud Mujeres Y Ninos

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Population surveys (BRFS, PRAMS, PedNSS, YRBS). Hotlines, print materials, media campaigns. Prepare, publish, and distribute reports. Development of models. Develop & promote MCH agenda & YR2000 National Objectives. Laboratory capacity. Identify high-risk/hard-to-reach populations.	Teen pregnancy. Teen parenting. Family Planning. Prenatal care. Building coalitions & partnerships.

Funding Sources:

Budget: $20,000.

MCH block grant funds.
Third party reimbursement (Medicaid, insurance)
Other: Grant is for an amount in excess of $200,000. However, the largest portion is designated for salaries. The Population Based Project is supplemented by Title XIX and XX Program Income.

Description:

The Corpus Christi-Nueces County Public Health District received a three year Title V Grant on September 1, 1996 to do outreach and education to promote the health and welfare of women and children in the two most densely populated areas in Nueces County, Texas. One of three components of the Population-Based Project of the grant was the formation of a "Safe Kid's Coalition." The Coalition is representative of a broad base of community leaders and is enthusiastic and hard working. Year one focus has been bicycle safety. Peer counselors will be trained in two to three middle schools in the fall of 1997 and will do actual presentations to groups of peers. Wearing a T-shirt with a logo derived from a poster contest held in one of the middle schools, counselors and trainers will have an abundance of literature, videos to show and incentives to hand out. To date, Public Service Announcements have appeared on local T.V. station. A news reporter from the station is a coalition member. There was also participation at a youth rally where literature and bicycle helmets were given out. Most recently, there was participation in a "Kids Fest" at a local shopping mall. Year two will add a home safety component and year three water safety.

Objectives:

The Corpus Christi-Nueces County Public Health District has received an invitation and plans to become a member of the "National Safe Kids Committee." Through local, state and national efforts, morbidity and mortality from bicycle accidents are expected to decrease. The State of Texas legislature also did not pass a law requiring the wearing of bicycle helmets. The Coalition plans to work toward getting a City Ordinance passed for Corpus Christi requiring wearing bicycle helmets.

Role of Local Health Department:

The Corpus Christi-Nueces County Public Health District has been involved in all planning from the time the grant proposal was written. We also have been monitoring and will evaluate outcomes on an annual basis. Prior to the hire of the Program Manager, the Director of Public Health Director of Nursing convened the Coalition. The program manager is now working with subcommittees of the Coalition and attends events herself. Coalition members and other volunteers do much of the implementation of the project.

Barriers Encountered:	**Strategies to Overcome:**
Difficulty in hiring an Registered Nurse to be the program manager.	Changed position title to Information Specialist and hired previous Information Spec.
Delays in getting State contracts.	Patience!
Delays in getting Commissioners Court "okay" to begin project.	Educating Judge and Commissioners and patience again.
Only one person managing program.	Assistance from Director of Public Health, Director of Nursing and Health Education Specialist.

Key Partners/ Collaborators:

Corpus Chrisit Independent School District.
KRIS - Channel 3 T.V.
Department of Human Service Child Protective Services
Nueces County Sheriff's Department
Corpus Christi Police Department
Corpus Christi Fire Department
Texas Department of Public Safety
Driscoll Children's Hospital
TCI Cablevision
Public Region 11
West Oso Independent School District

Accomplishments:

Organized a very active Coalition of community leaders interested in child safety.
Have become known in community and are being invited to participate in events oriented toward children.
Have been asked to join the National Safe Kids Campaign.
Planned for Year Two which begins September 1, 1997.

Lessons Learned:

Beside developing a greater patience for doing something worthwhile despite bureaucratic constraints, we have found an overwhelming desire in people to want to help to better the lives of children. Perhaps if there are enough "grass roots" efforts nationwide, the impact will reach persons with greater power to direct money and legislation toward making life better for children. Our focus, and that of the National Safe Kid's Committee is to decrease accidental injury and death. Much remains to be done in the area of abuse and neglect.

Taking it to the Streets

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:*	MCH Initiatives:
Analysis of demographics, economic status, behaviors, health status. Maternal, fetal/infant, child death reviews. Hotlines, print materials, media campaigns. Culturally appropriate health education materials/programs. Development of models. Newsletters, convening focus groups, advisory committees, networks. Provide infrastructure/capacity for MCH functions. Laboratory capacity. Provide outreach services. Transportation & other access-enabling services. Monitor enrollment practices for ease of use. Identify high-risk/hard-to-reach populations.	Low birthweight/infant mortality. Immunization. Early intervention/zero to three. EPSDT/screenings. Expanded child health services. Lead poisoning. Overcoming cultural barriers. Reducing transportation barriers. Expanding private sector links.

Funding Sources:

Budget: $1,890,000 (one time purchase cost)

City/County/Local government funds.
Private source(s): Mattel Foundation

Description:

The ever changing health care system motivates us to maximize resources. The City of Dallas Department of Environmental and Health Services is collaborating with new partners to assure preventive health services are provided in hard to reach areas of the community.

The Mattel Foundation awarded Texas Women's University (TWU) with the support of the City of Dallas, a grant for the purchase of a mobile health unit. The TWU nursing faculty and students and the City of Dallas Public Health Nurses will provide services at Head Start Centers and in Census tracts where immunization coverage is low and access to health care is limited.

This project is unique in that non-traditional partnerships have been formed to increase immunization levels and preventive health services within targeted areas. Identifying level and preventive health services within targeted areas. Identifying pockets of need and providing services which target the specific needs of these communities will empower the citizens to better access health care systems. In this emerging health care environment, innovative and collaborative partners are needed to assure continuity of care in all aspects of preventive health services.

Objectives:

Increase access to health care services for adults, women and children.

Outcome Measures:
Number of client services who previously had not accessed preventive services. Number of clients referred to medical home and tracked. Number of clients at benchmark of 6 months, annually continue to be active participants in a health care system.

Create opportunities at the community level for preventive health education to occur.

Provide training opportunities for health and human services/students at various levels of the education ladder.

Role of Local Health Department:

The Department of Environmental and Health Services has been an active partner from the idea to phase completion. Staff from TWU and the department met numerous times building in and ultimately reaching agreement on scheduling, targeted areas in the community and how to evaluate success of Mobile Outreach Unit.

Barriers Encountered:	**Strategies to Overcome:**
Coordination of community activities to prevent duplication among existing providers.	Development of a networking system that will enhance opportunities for collaboration and support irrespective of the lead agency.

Key Partners/ Collaborators:

Texas Woman's University
Grants and Contracts Division of City of Dallas - EHS
Mattel Foundation
Head Start of Greater Dallas

Accomplishments:

Mobile Unit and participates in various community sponsored health fairs. Mobile Unit provides health care services at targeted Head Start facilities.

Lessons Learned:

The greatest lesson learned from this effort was that bureaucracies exist in all institutions, but they too can be overcome if vested partners are committed and willing to put in the time and effort necessary to achieve their common goal.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Asthma and Breathing Problem Clinic

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Develop tools standardizing data collection, analysis, reporting Hotlines, print materials, media campaigns. Culturally appropriate health education materials/programs. Implement/support education services for special MCH problems. Provide infrastructure/capacity for MCH functions. Identify high-risk/hard-to-reach populations. Pediatric risk adjustment methods & payment mechanisms. Identify alternative resources to expand system capacity. Profiles of provider attitudes, knowledge & practices.	Expanded child health services. Overcoming cultural barriers. Expanding private sector links. Increasing social support. Case coordination. Staff training. Building coalitions & partnerships.

Funding Sources:

Budget:
$21,500

City/County/Local government funds.
MCH block grant funds.
Third party reimbursement (Medicaid, insurance)
Other: Sliding Fee

Description:

Development of a Monthly Asthma/Breathing Problems Special Clinic within the CFHS/ICAS Health Centers - Start up date: 9/20/94. In these special clinic sessions nurses provide families with comprehensive health education regarding all aspects of asthma triggers, prevention and treatment. The family is then seen by the pediatrician for an assessment, diagnosis and the development of an individual treatment plan. This is followed by an exit interview with a nurse to review the treatment plan, allow the family to ask any additional questions and ensure that the family understands the treatment plan.

Issues Addressed:

- Increased numbers of children with asthma/breathing problems within our client population.
- Frequent use of ER and Urgent Cares for treatment of asthma/breathing problems.
- Frequent hospitalizations for asthma/breathing problems.
- Lack of continuity of follow-up to manage children with asthma/breathing problems.
- Frequent absences from school due to asthma/breathing problems.
- Lack of client recognition of early symptoms of an asthma/breathing problem attach.
- Inappropriate/inaccurate medication usage.
- Lack of client understanding of triggers and causes of asthma episodes.
- Lack of client knowledge to self-manage asthma and other breathing problems.

Objectives:

- Fewer ER/Urgent Care/Hospital visits evaluated by subjective and objective reports.
- Fewer severe episodes of asthma/breathing problems evaluated by data collection from the child's medical record and

ER/Urgent Care/Hospital reports.

- Fewer missed days of school evaluated by client history.
- Better client management of asthma at home and school.
- Increased client understanding of asthma triggers and how to avoid them evaluated by client feedback/return demonstrations
- Increased client understanding of asthma medications and how and when to use them evaluated by client/family feedback/return demonstrations.

Role of Local Health Department:

The CFHS/ICAS Health Centers are a part of the Health District.

Barriers Encountered:	Strategies to Overcome:
Lack of client transportation. High cost of medicines/equipment. Need for babysitting to enable client/family to pay attention to education program. Length of time needed in clinic to complete health-ed physician exam & exit interview. Lack of computers in clinic for data collection and analysis.	Bus tokens offered. Social Work assistance with accessing community resources. Looking for volunteers to babysit in the clinic. Set aside small area in corner of patient education room for children to play while parents are given health ed. Work on fine-tuning health ed. process to decrease length time in clinic. Working with CFHS program to approve the purchase of computers for each site.

Key Partners/ Collaborators:

Collaboration has taken place with the agency epidemiologist and Wright State University School of Nursing Graduate student to develop and administer a client survey and develop a tool to gather client data to assist with outcome measurement/evaluation. Collaboration has taken place with the Dayton Area Health Plan managed care program. Collaboration has taken place with the Dayton Area Heart Lung Association.

Accomplishments:

- Completion of staff education.
- Development of schedules.
- Development of culturally appropriate educational materials i.e. videos, pamphlets, handout notebooks.
- Implementation of a nursing health education program and exit interview process.
- Development of client data assessment forms through collaboration of the Medical Director and Nursing Staff.
- Incorporation of the Nutritionist and Social Worker as team members in the assessment and educational process.
- Implementation of the monthly asthma/breathing problems clinics.
- Improved patient compliance with meds. and inhalers per the client survey.

Lessons Learned:

Patient/Parent are not keeping daily diary of peak flow as well as treatment used for various respiratory symptoms. Patients also stop treatment early, especially when patient is not having breathing difficulties. We are looking into providing patients with individualized written information on how to manage asthma depending upon symptoms as well as on peak flow, to help them self-manage asthma and to achieve our goals.

D&E Clinics with Care Coordination

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Replicated Elsewhere?
No

Updated Profile?
Yes. 1996

Essential MCH Functions:
- Culturally appropriate health education materials/programs.
- Newsletters, convening focus groups, advisory committees, networks.
- Laboratory capacity.
- Provide outreach services.
- Transportation & other access-enabling services.
- Review process for ped LT care admissions, CSHCN home services.

MCH Initiatives:*
- Children with special needs.
- Early intervention/zero to three.
- Expanded child health services.
- Overcoming cultural barriers.
- Reducing transportation barriers.
- One-stop shopping locations.
- Increasing social support.
- Case coordination.
- Increasing access to Medicaid.
- Building MCH data capacity.

Funding Sources:

Not reported

Budget: Not reported.

Description:

I have been involved in the establishment of a multi disciplinary evaluation clinic for Children with Special Health Care Needs (the Special Needs Clinic) for children of Denver Health (formerly known a Denver Health and Hospitals), an integrated public health system whose mission is to promote the health of Denver County/City residents. The clinic was started in July 1995 to provide comprehensive development evaluations and access to services for children with suspected or known special needs.

During the last year, I have received additional training with the support of the Colorado Department of Health and Environment to be qualified as a developmental pediatrician which enables me to perform Developmental Evaluations(D& E). Denver Health's Special Needs Clinic is now able to perform D& E and hence, better serve to needs of Denver County children and families.

I am now currently working with the staff of Denver Health Children and Families Program (DHCP) to better coordinate services for children with special needs and/or developmental concerns. DHCP, which is helping to provide services previously provided by the grant funded program, Healthy Tomorrows for Denver (1996 CityMatCH Member), serves families with children birth through 21 with special needs who reside in Denver City/County. DHCP provides service consultation, access and coordination to increase child and family access to and utilization of needed community health, education, financial and other services. DHCP also provides developmental support, access to a toy lending library and family support groups. The program is funded through two major sources from the Colorado Department of Health and Environment: The Health Care Program for Children with Special Needs and the Children and Youth Program. Our goal is to work together to establish an identification and referral system to assist children in need of a Developmental Evaluation, as well as develop a care coordination system.

Objectives:

Identification of children in need of a comprehensive, multi disciplinary Developmental Evaluation - outreach to clinics/providers regarding D&E.

Establishment of a referral process for D&E's through DHCP- Family intake, screening and assessment completed for DHCP for children referred - Pre-clinic conference for children referred to determine need and priority of D&E

Comprehensive, multi disciplinary D&E for identified children by the Denver Health Special Needs Clinic - recommendations to be shared with families, primary care providers and care coordinators.

Service coordination and follow-up for families.

We are also in the process of developing a computerized database which will provide information for study and tracking. I am particularly interested if families feel their child's needs are being met.

Role of Local Health Department:

The health department (Paula Hudson, PhD) has provided additional training for me in the area of development pediatrics, i.e. lectures, time with developmental pediatricians at Children's Hospital.
Material and information on the establishment of D&E's has been provided.

Barriers Encountered:	**Strategies to Overcome:**
Funding: *money=time=staff	Patience Use of personal time Support of Denver Health to free some of my time for extra developmental training, We are trying to obtain payment for service coordination by a Denver Medicaid managed care program, i.e. Colorado Access.

Key Partners/ Collaborators:

Denver Health Staff, i.e. members of the Special Needs Clinic team

Healthy Tomorrows for Denver staff.

Accomplishments:

All patients referred to the Denver Health Special Needs Clinic are also referred to DHCP and a case coordination team is assigned. The DHCP case coordination team assists the Special Needs Clinic staff in obtaining patient records.
The DHCP case coordination team helps schedule D&E's arrange transportation, arrange a translator if necessary and to schedule follow-up appointments or consultations.

Lessons Learned:

Not reported.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

WIC/Immunization Coordination

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:

- Develop tools standardizing data collection, analysis, reporting
- Implement public MCH program client data systems.
- Analysis of demographics, economic status, behaviors, health status.
- Community perceptions or health problems/needs.
- Culturally appropriate health education materials/programs.
- Special studies.
- Newsletters, convening focus groups, advisory committees, networks.
- Monitor enrollment practices for ease of use.
- Identify high-risk/hard-to-reach populations.

MCH Initiatives:

- Immunization.
- Early intervention/zero to three.
- Expanded child health services.
- One-stop shopping locations.
- Staff training.
- Building MCH data capacity.
- Immunization tracking/recall.

Funding Sources:

Budget: $450,000

Other Federal funds.

Description:

The Detroit Health Department Instituted a joint WIC Immunization initiative in 1993. This was initiated by checking shot records, providing parent education and trying to make immunization more accessible by placing an immunization clinic across the hall from the WIC clinic in the main building. In the fall of 1996, a coupon incentive program was started in conjunction with the state MTRACX program. Basically, WIC clients sign a contract agreeing to be a part of the program. They are not seen again until their next regular visit - 3 months. If their 0-12 month olds are not up to date on their immunizations or they have not brought their shot records, they receive 1 month of WIC coupons instead of 3. The program has gone from 42% up to date to 75% on the 4:3:1 series between January and July 1997.

Objectives:

The DHD-WIC Immunization program expected that immunization levels and presentation of shot records would improve. The speed of improvement has been even more substantial that anticipated. Baseline data were collected on all program participants and subsequent data has been collected on immunization status, % up to date, total assessed, new contracts signed, refusal to sign contracts, new contracts signed, and number of postcards mailed.

Role of Local Health Department:

Health Department staff was very much involved in planning, implementation and evaluation of the program. Evaluation is conducted by staff as well as through the CASA record assessment process which is computerized.

Barriers Encountered:	Strategies to Overcome:
Staff accustomed to cooperative relationships.	Careful planning
Change of Standard procedure	Staff education and participation
Some increased staff time for data entry and client return visits.	Acknowledgment of staff efforts, extra support.
Concern about losing WIC clients due to increased visits.	Active follow-up process.

Key Partners/ Collaborators:

Key partners have included the Michigan Department of Community Health, WIC division, and the Centers for Disease Control and Prevention.

Accomplishments:

- Up to date immunization status among 0-12 month old WIC clients went from 60% to 75% between January and June 1997.
- Data entry into the MTRACX system, which will be uploaded into the state registry by October 1997.
- Parents are now bringing shot records 90% of the time.
- A strong working relationship has been built between the WIC clinic staff and the Immunization Action Program.

Lessons Learned:

The greatest lesson learned from this program is that careful planning, attention to detail, staff involvement and client follow-up are key components of success.

Child Restraint Initiative

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Culturally appropriate health education materials/programs. Laboratory capacity.	Injury (including child abuse). Low birthweight/infant mortality. Other outreach activities.

Funding Sources:

Budget: $33,464

City/County/Local government funds.
Other: Highway Safety Initiative Durham's Partnership for Children

Description:

Durham County's statistics indicated that motor vehicle accidents contributed significantly to infant and toddler injuries. Studies show that appropriate use of child restraint seats can decrease the number of injuries and deaths for this age group. In December of 1995, the Durham County Health Department and Operation Breakthrough (the site for Head Start and a community based anti-poverty agency) secured grants from the N.C. Highway Safety Initiative and from Durham's Partnerships for Children to provide infant and toddler safety seats to low income families. Prior to this project, the only safety seat distribution program in the county was located at Durham Regional Hospital. To receive an infant seat on loan for 9 months, a $20 deposit and attendance at a limited training session were required.

Our project began with the purchase of 260 infant safety seats, 227 child safety seats and 15 booster seats. Staff coordinated the care seat program by offering 250 infant seats to families receiving prenatal care at the Health Department's clinic at the Lincoln Community Health Center, reserving 212 child safety seats for those returning infant seats for those families referred by the Health Center's Pediatric Clinic. Local police also referred families who were found to be violating the infant and toddler restraint law to the project. Additional seats were given to Operation Breakthrough to distribute through emergency services to homeless and indigent families. Education on the appropriate use of infant/child safety seats was included in our series of parenting classes. Each client was required to attend six parenting classes in order to be eligible for a seat. Individual sessions were also available if the parent was unable to attend the group session.

Objectives:

The expected outcomes of the infant seat distribution project were increased usage of child restraints in motor vehicles and reduction in motor vehicle injury and death. However, since the project is still in progress, it is premature to assess the overall injury morbidity and mortality reduction.

During FY 96-97, 197 individuals attended the complete series of parenting classes and received age appropriate safety seats.

Role of Local Health Department:

Staff from the Health Department took the lead role in problem identification, program implementation and evaluation by securing funding, forming a community network, providing injury prevention education, creating public awareness and submitting reports to the funding agencies.

Barriers Encountered:	**Strategies to Overcome:**
Securing mass media coverage, particularly television. Having limited storage for large quantity of car seats.	Using 30 second radio spots for advertisement; Establishing ongoing relations with local reporters. Negotiated storage space at several community sites.

Key Partners/ Collaborators:

Lincoln Community Health Center
Operation Breakthrough
City of Durham Police Department
Durham's Partnership for Children
Northeast Central Durham
Helping Families Help Children
N.C. High Safety Initiative

Accomplishments:

Networking and partnerships were found to focus on the problem; thereby increasing community awareness of infant/child motor morbidity and mortality as public issue.

Lessons Learned:

An informal survey indicated that 65-75% of the low income parents have a need for infant and toddler seats. To meet this demand on an ongoing basis will require reallocation of local dollars and/or securing funding from alternative sources.

Hepatitis A Immunization and Surveillance

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Analysis of demographics, economic status, behaviors, health status. Special studies. Labor capacity. Provide, arrange, administer direct services.	Immunization.

Funding Sources:

Budget: $30,000

City/County/Local government funds.
MCH block grant funds.
Private source(s): Sierra Medical Center

Description:

Children, ages 2-5 years old, will be offered immunizations against Hepatitis A infection which is endemic in certain census tracts of the City and County. The El Paso City-County Health and Environmental District coordinated efforts with the Houston School of Public Health satellite office in El Paso to identify areas where Hepatitis A infection occurs endemically. The computer software program used to determine annual Hepatitis A incidence rates by census tracts is Arco-Info. The information obtained is that most infections occur in communities closer to the Mexico Border, where people live in crowded conditions and are of low-socioeconomic means.

Objectives:

Identify city-county geographical areas by zip codes and census tracts that have an intermediate rate of Hepatitis A. Immunize children 2-5 years of age who reside in colonias and areas with intermediate rates of Hepatitis A. Report annual incidence rate

Role of Local Health Department:

The health department has been the leader in coordinating with the Houston School of Public Health in El Paso to produce the epidemiological study. The San Elizario School District was contacted to be a part of the study. Parent meetings were held to inform parents about the project. Most parents signed consent for children to receive the series. Tracking of children was done by a surveillance staff who worked closely with the school nurse to locate children who may have left the school system.

Based on a study done by the El Paso City-County Health and Environmental District, the Immunization and Surveillance Plan was developed to immunize 2-5 year olds. Texas Department of Health approved the plan and will send vaccine to health district.

Barriers Encountered:	**Strategies to Overcome:**
Vaccine received from TDH is short dated and must be used by October 18, 1997 (3000 doses) Vaccine supply will continue as long as TDH has funds.	Merck/Sharp/Dohme have agreed to provide vaccine free of charge to continue the project.

Key Partners/ Collaborators:

University of Texas Houston School of Public Health/El Paso, Sierra Medical Center, San Elizario School District, Title 19 Head-Start Program, Medical Alliance of El Paso, Merck/Sarpe/Dohme, Texas Department of Health Immunization Program, El Paso Independent School District, Tigua Indian Reservation Indian Bureau

Accomplishments:

During the last 2 years the health department coordinated with Sierra Medical and the Medical Alliance to do serological testing on children in Head-Start and first grade in an economically deprived community (San Elizario) to identify children who were not yet infected with Hepatitis A. Four-hundred twenty (420) children received a series of three Hepatitis A vaccine. The program has been extended to immunize children ages 2-5 years old in areas identified as high risk for Hepatitis A and immunizations are scheduled during late September and October, 1997. The project will be published in the American Journal of Public Health.

Lessons Learned:

Networking with other agencies and groups is cost-effective and provides services to community on issues that promote good health and prevent disease that can lead to early deaths. Each agency/group contributed by giving of their knowledge to develop the project.

Mothers First - The New Generation

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Replicated Elsewhere?
Yes. Adams County, CO

Updated Profile?
Yes. 1994

Essential MCH Functions:	MCH Initiatives:
Monitor enrollment practices for ease of use. Transportation & other access-enabling services. Culturally appropriate health education materials/programs.	Family violence. Increasing social support. Strategic planning. Substance abuse prevention. Injury (including child abuse).

Funding Sources:

Budget: $36,632

Private source(s): Grant from Colorado Children's Trust, Other: Agency In-Kind

Description:

The Mothers First program was initiated in 1992 (and reported on to CityMatCH in 1994) to help prevent fetal damage and to improve family functioning in a targeted population of pregnant women who use alcohol or drugs or who are experiencing significant psychosocial stress. In it's original form Mothers First provided on-site drug, alcohol and psychosocial assessment and counseling; home and clinic visits for support and teaching during the prenatal period and during the infant's first year of life; and referral to appropriate community resources. The program was launched in the city of Aurora, Colorado and expanded into Arapahoe County via a contract with Arapahoe County Social Services. In 1997, TCHD was awarded a $20,000 grant from the Colorado Children's Trust (the original funder of Mothers First) to launch Mothers First-The New Generation, an expansion of the program into Adams County, Colorado. Its goal is to promote positive parenting and increase family stability among high risk families with children under two years of age. This program expansion provides parenting and life skills classes and facilitates connections with other community resources and supports for the new generation of parents under 25 years of age who are clients of TCHD's WIC Program in Adams County.

Objectives:

Mothers First -- The New Generation uses six classes, each focusing on two outcomes measured by tools adapted from established curricula (e.g., Partners in Parenting Education and A Gentle Touch). Outcomes involve identifying or demonstrating: methods of conveying positive emotions, infant attachment behaviors, age-appropriate behavior expectations, positive strategies for regulating babies' behavior, unique characteristics of babies temperament and positive responses for these babies developmental levels in problem-solving, ways to encourage mastery through play, states of awareness and appropriate responses, engagement/disengagement cues and appropriate responses, good and bad stress reduction techniques, and self-care strategies.

Role of Local Health Department:

TCHD community health nurses, WIC staff and planning/evaluation staff are fully responsible for the planning, implementation and evaluation of Mothers First -- The New Generation.

Barriers Encountered:	Strategies to Overcome:
Recruitment of participants more difficult as we are no longer doing direct prenatal care. Clients might be adverse to attending a "class." Many clients have limited access to child care and transportation.	Recruit through our WIC program. Many clients under 25. Parents have established trust with their WIC Educator which might make them more open to the class invitation. Promote the class with an "invitation" to come "laugh, learn and play". Provide food! Wrote funds into grant to provide bus tokens and on-site child care.

Key Partners/ Collaborators:

This program offers the opportunity for an internal collaboration between the agency's nursing and nutrition divisions that hasn't existed in the past. This is one of a number of efforts to foster more inter-divisional collaborations internally. Externally, there are a number of family support agencies in Adams County who will refer clients to the program and will accept referrals from TCHD program staff. These agencies include Adams County Social Services, Lowry Family Resource Center, Crawford Family Resource Center, Adams County Mental Health and Clinic Campesina (an Adams County community health center).

Accomplishments:

In its first three years, the original Mothers First Program provided education, counseling, home visits and resource referral to 185 at-risk mothers. The funding for Mothers First-- The New Generation was awarded in July 1997. We are currently recruiting staff and developing the class materials and evaluation tools. Teaching will begin in September 1997. Our goal is to reach 180 parents in each of its six classes. It is our hope that many of the parents will attend all six classes, but due to the transience and high-stress lifestyle of our target population we have structured the classes so that each can stand alone.

Lessons Learned:

Too often, we tend to give up on a client who is non-compliant, who doesn't seen willing to work with us. Our experience with Mothers First -- and, we expect, with the New Generation -- is that clients who have substance use issues or severe psychosocial stressors have a disease and we need to stick with them as we would if they had cancer, for example. We wouldn't just quit on a woman who had breast cancer, we shouldn't just quit on a pregnant woman with substance abuse problems.
The other lesson we have learned is that group interaction and learning settings work for some people, but not all. Some thrive on the social interaction, but others do not have the skills to interact comfortably in a group setting. In Mothers First, we have learned to keep close tabs on each client to make sure that the group setting is working. If it isn't, we adopt a one-on-one approach.

CHC Services and TB Screening for Homeless Families at Shelter Location

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Develop tools standardizing data collection, analysis, reporting Implement public MCH program client data systems. Analysis of demographics, economic status, behaviors, health status. Tracking systems. Laboratory capacity. Transportation & other access-enabling services. Identify high-risk/hard-to-reach populations.	Immunization. Expanded child health services. Communicable diseases. Reducing transportation barriers. Other outreach activities. Building coalitions & partnerships. Immunization tracking/recall.

Funding Sources:

Budget: Not reported.

City/County/Local government funds
MCH block grant funds
Other: In-Kind provisions of medications and physical facility by ECHO

Description:

Beginning in April 1996, the Vanderburgh County Health Department's Child Health Clinic (CHC) in collaboration with the Evansville Collation for the Homeless (ECHO) began providing pediatric health services at the location of a homeless shelter/adult health center. Our staff includes a pediatric nurse practitioner, two RN's and a clerk. The clinic is open one morning a week with referrals being made to one of our three CHC sites for services as necessary at other times. Expansion is possible as the need for services increases for homeless shelter residents. We are also providing TB screening for all shelter families. This service enables them to obtain the screening without having to travel to the health department Communicable Disease Clinic.

Objectives:

1. Reduced infectious disease among the homeless population. Data tracking of TB infections in our community.
2. Increased preventive health care services for the homeless population. Data on children seen in our (CHC).
3. Increased rate of immunized children upon school entry. Data on numbers of children up to date on immunizations at school entry.
4. Reduced visits to Emergency room for acute illness for children in the shelter. Data on numbers of children seen for acute care.

Role of Local Health Department:

This is a collaborative effort by the VCHD and ECHO to provide services for homeless children. VCHD is providing the staff for pediatric health services, supplies and equipment for the clinic and immunization vaccine, including TB solution.

Barriers Encountered:	Strategies to Overcome:
Limited clinic hours. Limited staff. Under-utilization of preventive health care services by the very population that need it the most.	Referral to our CHC sites in the community. Staffing with other health department personnel as available. Education of facilities seen in our clinics on importance of preventive care.

Key Partners/ Collaborators:

The adult health center located in the homeless shelter. They provide clinic space for our services, some equipment and medications. The Communicable Disease Division of the health department. They provide follow-up, medications and examinations as necessary for shelter families with questionable and positive TB screens.

Accomplishments:

1. Easier access to health care for the families living in the shelter.
2. Collaboration with other social service agencies to reduce and prevent duplication of services.
3. Identification of persons who are at high risk for TB infection.

Lessons Learned:

The greatest lesson our health department has learned, is when the multiple barriers to accessing health care for at-risk children are eliminated, the services provided do make a difference in their quality of life and their future development. Working in a collaborative situation all staff need lots of flexibility, patience and sense of humor.

Violence Prevention

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Develop tools standardizing data collection, analysis, reporting Implement public MCH program client data systems. Hotlines, print materials, media campaigns. Develop & promote MCH agenda & YR2000 National Objectives.	Early intervention/zero to three. EPSDT/screenings. Violence prevention/at risk.

Funding Sources:

Budget: $118,000

MCH block grant funds.
Title V population based public health project.

Description:

Tarrant County has a population of 1,271,070 people. A 1994 crime report from the U.S. Department of Justice sited Tarrant County has having higher crime rates per capita than Texas or the United States. The project is three fold:
1. To provide a clearinghouse for information regarding existing Violence Prevention Programs.
2. To establish a coalition to reduce violent and abusive behavior in Tarrant County. The target population consists of all residents of Tarrant County since the entire population will be affected by the project activities.
3. To increase public awareness and parent education to reduce family violence in Tarrant County.

Objectives:

The Tarrant County Public Health Department will act as the lead agency to create a coalition in order to access the multi-disciplines dealing with violence prevention reporting and related service provision. A comprehensive resource assessment for victim referral and identification of gaps will be conducted with input/assistance of coalition members. A prevalence study of violence in a pregnant population will be conducted in health department WIC and prenatal clinics. This will be expanded to include education and screening for all prenatal care providers in Tarrant County. The coalition will work to develop uniform risk factor surveys, reporting, a collective database and improvement of statistical data over a three year period. The main thrust will be community wide education programs. The project will serve as a model for other communities and will allow for replication for statewide application.

Role of Local Health Department:

The violence prevention project has been an active participant in the Tarrant County Criminal Justice Planning Group. This participation has included attending six focus groups concerned with aspects of violence prevention. Our first year plan of coalition building has evolved into active networking to bring the various agencies into direct communication with each other. Our input into the focus groups has allowed us to present the health department as a major resource for community based activities, assessment and assurance activities valuable to high risk populations in Tarrant County. Most agencies in Tarrant County have a limited focus confined to their own program activities. As a public health agency, we have a holistic view of the needs and barriers to service delivery in the community. We also bring a public health perspective to the need for violence prevention to agencies that traditionally have a criminal justice approach and have underlined the connection between public health and law enforcement objectives. The need for uniform reporting of violence statistics has been recognized by focus group

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members through the efforts of our project members. Through our public health approach, we have increased the visibility of the department from a traditional role of providing disease control services, to one of a community based advocate for the entire population being affected by the issues related to violence. So far, no direct impact of our efforts can be measured in improving the health of our target community. However, our efforts in this first year have been strong in laying a long-term foundation for improving communication between agencies dealing with victims of violence and violence prevention activities. During the second year we have begun to implement the education program entitled *A Gentle Touch* by training public health staff and other agencies interested in the program which is designed to reduce family violence toward children 0-5. As this education program expands throughout the county, by the use of agencies' staff being trained to present the program, increased public awareness may be measured through an increase in referral activities and demand for community resources related to violence.

Barriers Encountered:	Strategies to Overcome:
Lack of communication between agencies. Fragmentation and lack of uniformity of major statistical data. A rapidly growing Hispanic and Vietnamese population.	The newsletter has increased communication between agencies and has a growing distribution. Educational materials are being translated into Spanish and Vietnamese. Teaching materials for the program *A Gentle Touch* are also being translated into Spanish.

Key Partners/ Collaborators:

During the first year of the violence prevention project, 67 agencies were identified as major participants in violence prevention activities as a result of participation in the Tarrant County Criminal Justice Planning Group. Through active participation in the group at large and small focus groups, we have established a presence in the community as an agency committed to violence prevention.

During the second year of the project, collaboration has been established with The Women's Center of Tarrant County, Camp Fire Boys and Girls Club of Tarrant County, The Parenting Center, Catholic Charities, and The University of North Texas Health Science Center's Graduate School of Public Health. We also have been invited to join the Hispanic Health care Professionals Association and Cowtown Educators.

Accomplishments:

1. An abuse assessment survey tool for pregnant women has been designed and implemented in English, Spanish and Vietnamese at the 19 WIC sites and other public health clinic sites within Tarrant County. The results of the survey, as of July 7, 1998, show that the incidence of abuse of pregnant women is 15.9%.
2. A video presentation of the program *A Gentle Touch* has been produced in English and Spanish. This video will be used in Tarrant County WIC and Public Health clinic settings and will be offered to agencies as a valuable violence prevention tool.
3. Staff training for the program is on-going. Other agencies are scheduled for the Train-the-Trainer sessions starting in August, 1998.
4. Publication and distribution of the Tarrant County Public Health Family Violence Prevention Project newsletter to 150 agencies.

Lessons Learned:

We have learned that there are services, funding opportunities, and creative programs available in Tarrant County but until this project began, we did not interface with the organizations/groups involved. Additionally, these groups did not know about the Tarrant County Public Health Department and what capabilities we have. The perspective of violence as a public health issue was never presented or considered by criminal justice groups. Through networking and education, we can all serve the community in a more holistic way. Until all agencies work together on preventing family violence, the problem will always be treated in a fragmented way.

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Prenatal and Early Childhood Services Study

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:*	**MCH Initiatives:**
Assessment of provider reports regarding process and outcomes. Development of models. Develop & promote MCH agenda & YR2000 National Objectives. Newsletters, convening focus groups, advisory committees, networks. Promote compatible, integrated service system initiatives.	Building coalitions & partnerships. Expanding private sector links. Strategic planning.

Funding Sources:

Budget: $40,000 this last year (FY 1996-97)

City/County/Local government funds.
General state funds.
MCH block grant funds.
SPRANS funds.

Description:

In an effort to reach our MCH Year 2000 objectives as outlined in our current Community Needs Assessment and Action Plan we formed a partnership with a major funder of non-profit community-based organizations serving women, children, youth, and families to conduct a comprehensive needs based community study focusing on pregnant women and children through age four (4) years in the county of Fresno.

Objectives:

Produce a written report targeting pregnant women and children through the age four years in Fresno County. The report, suitable for publication and distribution, will describe community needs, existing services, effectiveness of services, gaps and recommendations for how services might be coordinated, improved and/or added or deleted.

The report shall contain the results of a study to include a comprehensive analysis of all cohorts of assessment, interventions and outcomes with strengths, weaknesses and recommendations. The report shall include but not be limited to: 1) Identifying those major agencies and organizations that are currently serving pregnant women and children up to four years of age and provide an agency profile for each agency and organization.

2) Identifying all organizations and entities who deem it their responsibility, in whole or in part, to support the study population such as health and human service providers by way of example.

3) Compiling a list of critical issues, including pending situations and environmental impacts, that might serve as barriers for success or opportunities to improve and/or expand services and determine ways in which services might be provided in the future. This should include interviews with key stakeholders. A literature search will be implemented regarding this subject.

4) Validating the market population by zip code and, in some high-risk areas, by census tract.

5) Validating the inventory (comprehensive listing/record of all major agencies and profiling same regarding all services currently provided by agencies to pregnant women and children up to the age of four (4) years.

6) Defining all major agencies and their plans for expanding, reducing and maintaining services in the future.

7) Identifying the availability of services framed against the community need as defined from a data driven needs assessment.

8) Summarizing quotes and directions suggested by providers and leaders in the community and consumers.

9) Proposing recommendations (with time frames and approximate budget expenditures) to develop a long-term plan for

improving the health and welfare of children and their families in Fresno County.
10) Providing a matrix which shows services in relation to cost and volume analysis.
11) Projecting anticipated needs for the future generations of Fresno County.
12) Demonstrating where organizations should direct their resources for future investments for those services delivering the most value for the expenditure.
13) Report should plot existing services, needs, effectiveness of services, gaps and recommendations against the County's MCAH Year 2000 Objectives identified in the "Action Plan to the Year 2000".

Role of Local Health Department:

Our agency's role has been to provide public health data sets from our system, create a template for the structure of the study, provide direction on who to contact, type of information to collect and review/edit the work and review and approve the final report. We have also contributed information from our agency on services we provide in Community Health and Mental Health.

Barriers Encountered:	Strategies to Overcome:
Organizations do not collect good data regarding their services and demographics on who they serve. Lack of universal knowledge/understanding of what type of data to collect and what "outcomes" have to do with effectiveness of services and relevance of programs in the community. There is a sense of mistrust by a few in the community on what the study might show and how it could be detrimental to their organization/agency.	

Key Partners/ Collaborators:

A major funder for non-profit community-based organizations in the community and all the organizations/agencies in the county who serve pregnant women and children to age 4 as well as key policy makers who have been interviewed. The entire community has been very supportive.

Accomplishments:

Not reported.

Lessons Learned:

This project was not completed in accordance with the specifications for the work as outlined in the contract and therefore, the study was not published or distributed. In spite of eighteen meetings with the MCAH Director, our 12 months and technical assistance from experts in data and evaluation, the CBO was unable to produce a document which would accomplish the objectives. The greatest lesson learned is the recognition that in spite of the best intentions, public-private can become side-tracked by special interests in an attempt to promote their own agendas.

This activity requires a very well constructed plan in advance of the project; collaborators who share the same vision and a contractor with the expertise to perform the work. It also requires the MCH program have strong performance capabilities in the core public health functions, especially data analysis and policy development. The purpose must be clear to the community that we are creating a tool which will assist the community in planning for improving the system serving pregnant women and young children in order to improve the health and well being of the population served.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Prec-Inct Clinic

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:***
Hotlines, print materials, media campaigns. Culturally appropriate health education materials/programs. Newsletters, convening focus groups, advisory committees, networks. Laboratory capacity. Monitor enrollment practices for ease of use. Identify high-risk/hard-to-reach populations. Pediatric risk adjustment methods & payment mechanisms.	Immunization. EPSDT/screenings. Expanded child health services. Injury (including child abuse). Lead poisoning. Dental programs. Overcoming cultural barriers. One-stop shopping locations. Building coalitions & partnerships.

Funding Sources:

Budget: $10,000

City/County/Local government funds.
MCH block grant funds.
Other Federal funds.

Description:

A new collaborative effort between The Gary Housing Authority's Drug Elimination Program which includes the Boys and Girls Club and four divisions of the Gary Health Department's Health University was implemented May 1997. The purpose of this initiative is to increase accessibility to health care to the low income population by providing services on-site in five (5) housing developments. The MCH clinic services include physical exams, hearing, vision, labs, immunizations and education. Referrals to the clinic included dental exams and prenatal care. Other services to promote one-stop-shop include WIC, Healthy Start education classes, Prenatal Substance Use Prevention Program classes, and the computer workstation for classes.

Objectives:

To increase the availability of health care to an under served clients.

To promote one-stop-shopping.

To provide a safe alternative for summer and after school activities.

To inform parents of the benefits of well child exams.

Role of Local Health Department:

The Health Department has been very active in planning and implementation phases. The Health Department has organized four departments to implement an outreach program. The departments and services include MCH, immunizations, STD/HIV, nutrition, and substance abuse. These departments provide services as well as health promotion through education classes.

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Barriers Encountered:	Strategies to Overcome:
Reluctance of staff and parents to allow the children to participate.	Staff and parents observed screenings and realized no inconvenience were placed on them or their activities. Appreciated results given immediately. Both parents and staff stated they learned in educational classes.

Key Partners/ Collaborators:

Gary Housing Authority
Boys and Girls Club
Methodist Hospital
WIC
Healthy Start

Accomplishments:

Implementation of Services

June: 19 physical exams
153 hearing screens
153 visual screens
7 dental exams (cleaning and fluoride)
6 education classes (lead poison and CPR)

Lessons Learned:

The Health Department's staff perception of the Housing Developments changed. After the initial service was provided, they were pleased with the environment and eager to return.

Another valuable lesson learned is that community-based agencies can come together to make a difference and address various health issues.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Child Death Counseling

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E-mail

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status. Environmental assessments. Culturally appropriate health education materials/programs. Prepare, publish, and distribute reports. Identify high-risk/hard-to-reach populations.	Injury (including child abuse). Case coordination. Strategic planning. Infant/child death review.

Funding Sources:

Budget: $63,000

City/County/Local government funds.

Description:

The Child Death Review Team in Kent County has been meeting since January, 1996. During the process of reviewing child deaths, it was noted that our health department SIDS program staff provided excellent counseling and follow-up services to all families who had a child die of SIDS. Death review committee members questioned if this service could also be provided to families who had a child die due to other reasons (e.g. drowning, accident, etc.). As a result of this discussion and with the support of the Health Officer the county developed a plan to have the specially trained nurses or social workers that were involved with SIDS to also provide counseling to families and significant others on all sudden, unexpected deaths (Medical Examiner cases), not just SIDS. Although we have a considerable number of deaths due to prematurity and other conditions immediately following birth, this is considered a subgroup to our committee, and at this time not included in the project. The Medical Examiner notifies the committee after a death and a staff person is assigned. The staff person makes contact with the families to offer services. Home visits are made as needed and whatever resources and referrals needed by the family are provided.

Objectives:

Outcome measures are still being developed. Grief counseling home visits, referrals made and support group attendance are monitored. A satisfaction survey may also be used to assist in the evaluation process.

Role of Local Health Department:

The Health Department has played a major role including approval for funding and planning. The implementation phase is still in process and requires more work. Evaluation has not yet been finalized.

Upon referral from the Medical Examiner, the department provides the public health nurse and/or social worker who then contact the family for follow-up and counseling. The health department has provided statistical data and health related information to the review team.

Barriers Encountered:	Strategies to Overcome:
Inability to locate families. This is a problem when a fire has occurred and the family relocates. Cultural issues surrounding grief process.	Networking. Exploration of options available for cultural needs. Seeking advice from knowledgeable resource persons representing the cultural background.

Key Partners/ Collaborators:

The key partner is the Medical Examiners Office. The Kent County Child Death Review Team includes the Grand Rapids Police Dept, Grand Rapids Public Schools, Kent County Juvenile Court, Sheriff's Dept, Office of the Prosecuting Attorney, four local hospitals, Child and Family Resource Council, Children's Assessment Center (for abused children), Community Mental Health, Kent County Dept of Family Services (Family Independence Agency).

Accomplishments:

Most families are receiving the service. Some have refused and some are not located due to relocation.

Improved networking with surrounding counties regarding deaths where the child is a resident but has been seen in a Kent County (Grand Rapids) hospital. Grand Rapids is the largest metropolitan area on the west side of Michigan and residents of many other counties utilize the four hospitals.

Lessons Learned:

To utilize expertise learned through our SIDS Program in providing service to grieving families. This expertise is being expanded to dealing with families who have lost a child by other means than SIDS. The Child Death Review Team members have recognized the benefits of extending this service to all families in the community.

Guilford Child Health, Inc.

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives**:
Identify high-risk/hard-to-reach populations.	Expanded child health services. Expanding private sector links. Building coalitions & partnerships.

Funding Sources:

Budget: $1,000,000

City/County/Local government funds.
Private source(s): Moses H. Cone Health System, Wesley Long Community Hospital, High Point Regional Health System

Description:

Guilford Child Health, Inc. (GCH) is a Public-Private Partnership to provide pediatric primary care. Community-based planning for this partnership involved political leaders, clients, hospitals, physicians, Health Department staff, business leaders and other interested citizens. County now contracts with GCH, a non-profit company formed by the 3 hospitals. The first clinic opened in Greensboro in January, 1997. High Point clinic opened June 1997 and Devon, a neighborhood clinic, in July 1997.

Objectives:

Primary Care Services will be provided to 10,000 children previously provided by the County Health Department.

In 3 years services will be expanded to 20,000 children at no additional County cost.

Quality Assurance measures for number of clients, immunization rates, accessibility of appointments and a grievance procedure are built into the contract.

Role of Local Health Department:

Health Department staff took leadership role in the initial planning and coordination of transition. Health Department staff continue to act as consultants during initial implementation and provide evaluation of quality measures and outcome measurements.

Barriers Encountered:	**Strategies to Overcome:**
Acceptance of change in service provider by the clients and community. Concern of staff at being displaced.	Frequent communication with clients and community. Only 1 staff member was not placed in another position.

Key Partners/ Collaborators:

Moses H. Cone Health System
Wesley Long Community Hospital
High Point Regional Health System

Accomplishments:

Transition of clients to new facilities.

Increased hours of service to clients.

Lessons Learned:

To be very specific in the contract as to the definition of responsibilities of each partner, costs assigned to each partner and dates reports are due. Also, a great amount of staff time is involved in the initial planning, transition and implementation periods. Health Department staff time continues to be involved even after start up is complete.

Maternal and Infant Outreach Program (MIOP)

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Replicated Elsewhere?

Updated Profile?
Yes. 1996

Essential MCH Functions:	MCH Initiatives:*
Environmental assessments. Hotlines, print materials, media campaigns. Provide infrastructure/capacity for MCH functions. Laboratory capacity. Provide outreach services. Monitor enrollment practices for ease of use.	Preconception promotion. Prenatal care. Lead poisoning. Violence prevention/at risk. Communicable diseases. Family violence. Dental programs. Other outreach activities. Increasing social support.

Funding Sources:

Budget: Not reported.

Other: NHWs volunteering their time to accomplish this goal.

Description:

In the past year, the Maternal and Infant Outreach Program (MIOP) began offering Doula services as an extension to the home-based prenatal/postpartum education, socioemotional support; advocacy and case management services provided to low income, high risk pregnant and postpartum women and infants. As Doulas, MIOP's NHW's provide information, education, support and physical comfort to the laboring woman. Additionally, the Doula serves as a support person to the partner and facilitates communication between the woman, her partner and medical providers. Doulas provide an objective point of view and assistance to women in getting her the information she needs so she can make an educated decision. In 1995, 8 NHWs received training as Doulas. In 1997, the remaining 8 NHWs and support staff received Doula training as well.

A MIOP Doula understands the physiology of birth and emotional needs of a woman in labor, which play a critical role in the successful delivery of a healthy baby.

Objectives:

The ultimate goal of MIOP's Doula program is to preserve the birth as a key life experience that the mother will remember all her life. The expected outcomes of a Doula assisted delivery compared to a non-Doula assisted delivery includes fewer cesarean births, fewer epidural requests, less analgesia and oxytocin use, as well as a shorter labor. The effectiveness of the program will be determined by the results of a study comparing the birth experience of MIOP clients who had a Doula assisted delivery with a matched sample of clients who did not have a birth Doula.

Role of Local Health Department:

- The Hartford Health Department has played the role of facilitator in discussions with the hospitals.
- The Hartford Health Department has supported MIOP's search for outside funding when financial support was not available from within the Health Department.

- Currently, the Hartford Health Department and MIOP staff are working obtaining an outside consultant to further evaluate MIOP data.

Barriers Encountered:	**Strategies to Overcome:**
Sometimes hospital resistance to having more than one support person in the delivery room in instances when a family member is also participating in the delivery. Securing funding for the training. High rate of staff turn over resulting in the need to search for funding for training of new staff.	Meetings with clinical care providers at the hospital to educate them on the benefits of having a birth Doula to gain commitment for the program. Funding has been sought from outside sources.

Key Partners/ Collaborators:

Deputy Director of Health
Senior Project Manager
Grants Manager

Accomplishments:

- To date, half of MIOP's staff members have participated as Doulas in at least one birth.
- Currently, 100% of MIOP's staff completed the Doula training and are working on obtaining certification.
- To our knowledge, MIOP is the only agency providing Doula services to this population free of charge.

Lessons Learned:

1. The marvelous commitment of MIOP staff with the mothers-to-be and their babies.
2. The outcome of this effort is now being reflected in the hospitals' awareness of the need of this service for all their clientele and their willingness to negotiate some reimbursement for this service.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Healthy and Hapai Pregnancy Calendar

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Replicated Elsewhere?

No

Updated Profile?

Essential MCH Functions:

Hotlines, print materials, media campaigns.

MCH Initiatives:

Prenatal care.
Overcoming cultural barriers.
Expanding private sector links.

Funding Sources:

General state funds.
MCH block grant funds.
Private source(s): Meadow Gold Dairies

Budget: $15,000

Description:

The Healthy and Hapai Pregnancy Calendar is a culturally sensitive educational self-help tool to promote healthy lifestyles during pregnancy. ("Hapai" means pregnant in Hawaiian.) The calendar contains information on community resources and health tips for mother, baby, and family. The calendar also includes various cultural beliefs about and practices during pregnancy. Hawaii is a culturally diverse state, with approximately 70% of births to women of ethnic groups other than Caucasian. A culturally sensitive tool is especially important because Hawaii has clear ethnic disparities in birth outcomes. The ethnic groups with poorer birth outcomes are often those with poor socioeconomic status and poor access to prenatal care. The calendar was developed by Healthy Mothers, Healthy Babies Coalition of Hawaii in consultation with the Hawaii State Department of Health. Since 1991, over 20,000 copies have been distributed at cost ($2.75 each) to community agencies and providers who have provided them free of charge to their clients. The primary beneficiaries of the calendar have been low-income pregnant women, pregnant women in ethnic groups at high risk for poor perinatal outcomes, and pregnant teenagers.

Objectives:

The objectives of this project are to encourage healthy lifestyles in the overall context of women's lives and pregnancy; to contribute to the improvement of pregnancy and birth-related health indicators in our state, and to promote access to important resources for women. The calendar is used in collaboration with other perinatal programs and providers in the state which serve the primary beneficiaries noted above. It is integrated into the overall educational strategy of these programs/providers and as such, is expected to contribute to the improvement of perinatal indicators, e.g. low birthweight, in the state. This integration also assures that a knowledgeable person will teach the client how to use the calendar.

Role of Local Health Department:

The Hawaii Department of Health (DOH) has actively collaborated with the Healthy Mothers, Health Babies Coalition in the planning, implementation and evaluation of the calendar. This partnership with the DOH has shared in the credibility of this product. In addition, the DOH has provided the major source of funding for the Healthy Mothers, Healthy Babies Coalition, which has done the actual staff work on this project.

Barriers Encountered:	Strategies to Overcome:
Implementation of this project has gone relatively well. Programs and providers which serve the target populations have purchased the low-cost calendars and distributed them free of charge to clients. However, there has been a decrease in state funding and there is concern about how to continue wide distribution. Improved marketing and affordability will be pursued.	Not reported

Key Partners/ Collaborators:

The key partner has been the Healthy Mothers, Healthy Babies Coalition of Hawaii which has taken a lead role in this project. Other key collaborators have been community-based perinatal programs subsidized by the DOH; contributors to the content, artwork and design mentioned in item #3 above; and a local corporate sponsor, Meadow Gold Dairies, which has contributed funding for publishing the calendar.

Accomplishments:

Since the calendar's inception in 1991, a major accomplishment has been improvement in its acceptability and accessibility by high risk clients. The calendar is unique in that it includes cross-cultural information specifically applicable to Hawaii's diverse ethnic population. It is also literacy-appropriate for people who have English as a second language. Another accomplishment is the successful partnerships which have developed. The original draft was completed over two years with a volunteer committee; the current artwork was contributed by noted Hawaii artist Pegge Hopper; and other calendar illustrations were contributed by a number of community volunteers and a local design company. Private funding has also been secured for publishing the calendar.

Lessons Learned:

The greatest lesson for DOH has been the importance of collaboration between the public and private sectors in a project with clear value to a target population in need. Another lesson has been the importance of evaluation of the calendar itself, separate from the comprehensive efforts of the perinatal program which uses this tool. Toward this end, the Healthy Mothers, Healthy Babies Coalition is looking at a postpartum evaluation of the calendar by having clients complete a simple survey.

Indianapolis Birthing Project/SisterFriend

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Replicated Elsewhere?

Yes. Sacramento, CA

Updated Profile?

Essential MCH Functions:

Not Reported

MCH Initiatives:

Home visiting.
Low birthweight/infant mortality.

Funding Sources:

City/County/Local government funds.
Private source(s).

Budget: Not reported.

Description:

We are a community-based volunteer organization using the big sister-little sister volunteer model to provide support and advocacy in identifying and obtaining prenatal care. We are a replication of the Birthing Project in Sacramento, California, which was established in 1988 and has proved itself successful in its mission of helping pregnant women receive necessary health care. The Indianapolis Birthing Project is a joint program of Marion County Health Department and Project Concern International. Funding for the project has been generously provided by the Marion County Health Department, The Lilly Endowment, and the Moriah Fund.

Objectives:

The Indianapolis Birthing Project's goal is to encourage family planning and birth spacing by training volunteers to encourage early prenatal and postnatal care as well as well baby care and immunization. Clients are made aware of resources in the community to assist them with job training.

Role of Local Health Department:

The Health Department plays a role in our financial stability. Health Clinics, nurses, and the community provide referrals to the program. Outreach staff contacts referred clients to enroll them into the program.

Barriers Encountered:	Strategies to Overcome:
Lack of prenatal care.	Due to lack of social services provided to clients, jobs, housing and educational resources are made available to them whenever possible.

Key Partners/ Collaborators:

Key partners/collaborators in this activity include: Maternal/Child Health, Mother Baby Healthline, Entermed, Inc., Training Inc., Care Coordination, Village House, Goodwill Industries and Indypendence Career Center.

Accomplishments:

Since inception over 325 clients have been mentored and paired with volunteers. The average birth weight of babies born in the IBP is 7lbs 5oz. There have been 2 infant deaths, and 3 repeat pregnancies.

Lessons Learned:

By encouraging pregnant teens/women to obtain prenatal and postnatal care, we can decrease the infant mortality rate. The community works together to encourage pregnant teen/women as well as offering emotional support and understanding instead of being angry that it happened.

Jackson Medical Mall

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Not reported	Not reported

Funding Sources:

Budget: Not reported.

City/County/Local government funds.
Private source(s): The Jackson Medical Mall is a not for profit venture which is unique we believe in the US.

Description:

The Jackson Medical Mall is a non-profit project designed to provide medical care with emphasis on MCH in a seamless manner from prevention, prenatal care, high risk maternity, pediatrics, immunization at the site of a revitalized inner city mall.

Objectives:

1. "Seamless" health care for our citizens.
2. All support and health services in one place.
3. Revitalize a neighborhood.

Role of Local Health Department:

Partnership with mall board and University Medical Center.

Barriers Encountered:	**Strategies to Overcome:**
Money Cooperation of area providers.	Support of county/financial institutions and other financial institutions.

Key Partners/ Collaborators:

Don Grillo, MD

Accomplishments:

1. Health Department is placed.
2. Primary care center is current limited capacity.
3. University to open in January 1998.

Lessons Learned:

Communication!

Alternatives to Abortion: Pilot Project

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:

Hotlines, print materials, media campaigns.
Culturally appropriate health education materials/programs.
Implement/support education services for special MCH problems.
Special studies.
Provide infrastructure/capacity for MCH functions.
Laboratory capacity.
Transportation & other access-enabling services.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.

MCH Initiatives:

Preconception promotion.
Family Planning.
Expanding maternity services.
Teen pregnancy.
Teen parenting.
Expanding private sector links.
Staff training.
Building coalitions & partnerships.
Infant/child death review.

Funding Sources:

Budget: $350,000

General state funds.

Description:

Funding was provided for a six month pilot project (starting in October, 1996) in Kansas City to reduce the number of abortions, subsequently reducing the State's total number, through offering alternative services to women at risk for abortions. The project must demonstrate cooperation among a diverse collaboration of private/public health agencies/providers. They must create a continuum of services ranging from pregnancy testing through post delivery/abortion services, including job readiness training. There must be a determination of need, evaluation of existing programs, establishment of best practices, education of all parties involved, identification of existing gaps in services and coordination of effort to be successful in reducing the number of abortions in Kansas City.

Objectives:

To reduce the number of abortions in MO by the initiation of alternatives to abortion services through the following objectives:

- creation, implementation and evaluation of a pre-screen needs assessment survey
- establishment of a public/private agency consortium
- creation of a service continuum, pregnancy testing through post delivery/abortion services
- non-directional counseling education of participating agencies
- development of education material to present alternative services to pregnant women
- evaluation of whole project (if funding becomes available)

Role of Local Health Department:

The Health Department has been involved at all levels, including planning, budgeting, application and committee participation. Has become a facilitator between the public and private agencies/providers involved to ensure cooperation and civil negotiations. Will continue to be involved in the evaluation and assessment process, if funding becomes available.

Barriers Encountered:	Strategies to Overcome:
Lack of positive/active support towards abortion alternatives.	Publication of newsletters, pamphlets and booklets that state all options in a non-biased light.
Contract time was only six months long; hard to get sub-contracts approved and supported by the public.	Massive and all-inclusive press/media releases with full cooperation of all agencies/providers involved.
Lack of support counseling of peers, relatives or partners to support mother's choices/alternatives.	Possibly implement/include those affected in peer counseling or support groups.

Key Partners/ Collaborators:

Catholic Charities of Kansas City-St. Joseph
The Light House
Maternal and Child Health Coalition of Greater Kansas City
Planned Parenthood of Mid-Missouri and Eastern Kansas
St. Luke's Hospital
Truman Medical Center
University of Missouri-Kansas City
Women's Employment Network
Missouri Department of Health (funding source)

Accomplishments:

- Coordination of nine different agencies/providers to provide a wide range of resources to area women.
- Development of a pre-screen needs assessment survey.
- Non-directional/judgmental training of care staff (case managers, nurses, etc.)
- Development of a "Guide to Community Resources" for women of child-bearing ages to use to locate services they need.

Lessons Learned:

Even though the participating public and private agencies/providers have very different philosophies, approaches to health care, ideas and beliefs they were able to set their differences aside, join forces and coordinate their efforts to provide services to the pregnant women of Kansas City. This sets a precedent for other public/private funded projects to follow.

Teen Counseling Initiative

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Replicated Elsewhere?

Updated Profile?

Essential MCH Functions:
Hotlines, print materials, media campaigns.
Ombudsman services.
Monitor enrollment practices for ease of use.
Profiles of provider attitudes, knowledge & practices.

MCH Initiatives:
Family Planning.
Communicable diseases.
Overcoming cultural barriers.

Funding Sources:

Budget: Not reported.

City/County/Local government funds.

Description:

Knox County Health Department recognized (1) the need to have a structured method of ensuring that pregnant clients are receiving prenatal care as early in their pregnancy as possible, and (2) that teen pregnancy needs to be reduced or at least delayed as long as possible. Clients coming to the health department for pregnancy tests are channeled into either case management or counseling and education activities. Those clients who have positive pregnancy tests are referred to a social worker for case management and assistance to apply for TennCare (Medicaid waiver program) and prenatal care. Clients are also assisted with other needs as appropriate. Clients who have negative pregnancy tests are referred to a social worker for age appropriate education and counseling.

Many of those who test negative are teens and the counselor has developed an educational program that deals with development, responsibility, education needs, emotional needs, sexuality transmitted diseases and birth control education including abstinence as an option. The counselor strives to put the teen at ease and involve her in the process in order to target the education to her specific needs in a realistic manner.

Pregnancy tests are performed on a walk-in basis daily with extended hours up to eight o'clock on two evenings each week. The counseling is offered at the time of the test in an effort to reach as many of the teens as possible and eliminate the need to schedule an appointment.

Objectives:

The goal of the counseling of the teens is to delay pregnancy, allowing these teens to complete their education and become mature enough to be able to provide a home environment that would be conducive to child rearing. A secondary goal would be to reduce the number of (1) low birth weight babies and (2) those pregnancies that result in a poor outcome.
To date this program has not been evaluated, but we do have the capability of retrieving a list of clients counseled and could do a retrospective study of those who later became pregnant and at what age.

Role of Local Health Department:

Health department family planning and social work staff conceived the idea of providing targeted counseling after a review of the number of teens coming to the health department for pregnancy tests. The clinic staff set goals and established implementation procedures. After review, the staff were given the wholehearted approval administratively to proceed. To date evaluation has not been done but it is our belief that we are nearing a point where we need to develop the evaluation piece.

Barriers Encountered:	Strategies to Overcome:
A clinic location that provides some anonymity. Encouraging staff to buy-in and encourage clients to participate.	The health department has undergone a renovation and construction project which has necessitated that the clinic be moved several times. A permanent location has been assigned and will be evaluated to ensure that this is the best location. Providing updates and education to staff regarding the benefits both short and long term for this project.

Key Partners/ Collaborators:

Health department staff from the family planning program, the social services department, health promotion staff and nurses in middle and high schools that have a higher number of pregnant teens.

Accomplishments:

The program has been well received by the majority of the teens participating and it is our belief that the provision of health education information leads to better choices and increased self-esteem.

Lessons Learned:

Targeted health promotion and health education activities for teens requires a program that can be adapted to varied levels of understanding and needs to be separated from regular family planning services. The most important lesson we have learned is that we need to establish a teen clinic that can deliver targeted services in an atmosphere that will be conducive to their learning and development. Plans are being developed to start such a clinic in the near future.

Teen Outreach Project

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Laboratory capacity. Transportation & other access-enabling services. Referral systems, resource directories, advertising. Monitor enrollment practices for ease of use. Comparative analysis of HC delivery systems.	Family Planning. School-linked/based services. School & health connections. Other outreach activities. Building coalitions & partnerships. Building MCH data capacity.

Funding Sources:

Budget: $25,000/annually

Other Federal funds.

Description:

The Teen Outreach Project started in the fall of 1994 and was initially funded at $25,000 annually for 2 years. It is a joint effort between the health department's Community Health Services and Health Promotion & Lifestyle Management Divisions. The goals are to increase the number of teens utilizing family planning services and to decrease teen pregnancy. A Community Health Outreach Specialist with experience working with adolescents, implementing adolescent programs, assessing community needs and with group facilitation skills was hired for this project. Utilizing focus groups, community meetings and surveys, barriers for teen accessing services were identified and removed.

Objectives:

1. To identify barriers to family planning services in serving the teen population.
2. To improve access to family planning services by removing barriers.
3. To provide community outreach activities to teens.
4. To increase the number of teens served in the health department's family planning clinic from 750 to 825 clients by December 1996.

Role of Local Health Department:

The health department was the lead agency and responsible for obtaining funding, conducting focus groups, completing surveys and analyzing data. Improving access to care involved the following: increasing evening clinics, providing walk-in services, offering emergency contraceptive pill services, prescribing oral contraceptives without a pelvic exam, improving telephone services for appointments, information, etc., decreasing the wait for an appointment.

The Community Outreach Specialist implemented the following activities: forming an advisory group, volunteering for committees, boards, community events, etc., developing 50 minute classroom presentations on contraception, HIV, STD, etc., presenting to approximately 2000 teens per year, developing marketing materials such as cards, napkins, resource packets, etc., offering a one day teen sexuality workshop to high school peer counselors, training peer educators to do presentations.

Data on the number of teens served was collected quarterly. The advisory board met every two months to provide direction to the project. This board also helps to identify strategies that have worked to increase the number of teens served.

Barriers Encountered:	**Strategies to Overcome:**
Implementing clinic charges to improve access. Creating relationships with community members. Creating a partnership with the schools.	Involving staff and keeping them informed every step of the way. Follow up focus groups with staff to identify ongoing barriers. Focus groups to identify concerns and issues. Serving on committees or community events. Letters sent to high school principals, biology, health teachers, counselors, etc. re: the project. Linking school and department staff to improve communication. Including school staff on the project advisory committee.

Key Partners/ Collaborators:

Jefferson County Department of Health & Environment/Community Health Services Division/Health Promotion and Lifestyle Management Division

Colorado Department of Health & Environment/Women's Health Section/Family Planning Program

Jefferson County School District R-1

Accomplishments:

Focus groups with adolescent clients, clinic staff and community groups identified changes to improve access to care. By removing these barriers, in 1996 the goal was met when 923 adolescents were served, 98 more teens than the stated project goal.

In 1997, the project in partnership with the Jefferson County School District was recognized by US West for helping to make the Denver Metro Area a better place to live. The school district also awarded the project's outreach specialist the "Counselor of the Year Award" for support given to students. In July 1997, the project was funded indefinitely by the Colorado Department of Health Women's Section.

Lessons Learned:

To continually improve existing services.

To involve clinic staff in the process so that positive relationships with Outreach Specialists are established.

Be patient. It takes a long term investment in community outreach before results are seen in clinic appointments.

"All Their Shots While They're Tots"

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:

Maternal, fetal/infant, child death reviews.
Culturally appropriate health education materials/programs.

MCH Initiatives:

Immunization.
Reducing transportation barriers.
Expanding private sector links.
Building coalitions & partnerships.
Communicable diseases.

Funding Sources:

Budget: Not reported.

Private source(s): Humana, Rite Aid

Description:

In June 1997, the Lexington-Fayette County Health Department staff were asked to participate in a partnership with Humana Health, Rite Aid Pharmacies and the Kiwanis Club in initiating an infant immunization educational campaign. The campaign kick-off was July 21, 1997. The campaign was held from July 21, 1997 to August 9, 1997. The campaign consisted of billboards, payroll inserts, radio-television public service announcements, posters, and a speakers bureau. The slogan was "All Their Shots, While They're Tots".

Free vaccinations were offered to all infants and those up to 2 years of age at four Rite Aid Pharmacies and two Humana Clinic sites. The Lexington-Fayette County Health Department offered free vaccinations for this same age group during this campaign.

Several group planning meetings were held in addition to several agency meetings. The Health Department provided the free vaccine and training for the nurses providing the service at the Rite Aid and Humana locations. The Health Department also provided the informed consent information. Humana nursing staff provided the service at the Rite Aid and Humana Clinic sites and the Kiwanis Club members registered clients and assisted with the activities relating to the service in addition to making the time spent at the sites enjoyable. Clowns were on hand to amuse not only the children but also the parents at the six sites in addition to distributing posters and flyers in the community. Incentives were given to participants at each site.

This was a partnership which was able to join together to reach a common goal of increasing the immunization level of infants and children up to age 2. The partners had a short time frame to complete the task developing and implementing the campaign.

All sites were located on the bus route and 3 were located near low income housing. One community center provided transportation to the site for those parents needing transportation.

At this writing, ten more clinics are to be held. The data analysis is not complete. We are hopeful that this approach with a partnership will have positive results.

Objectives:

Increased immunization level in 0-2 year olds in Lexington.

Increased public awareness of immunizations and their need.

Increased harmony and good will between the public and private organizations.

Belief in the effectiveness of future collaborations.

Humana is doing statistical reports on numbers of clients seen, number of specific vaccines given and which sites.

Role of Local Health Department:

Please see activity summary from #1.

Barriers Encountered:	Strategies to Overcome:
Coordinating record keeping after shots are given.	Humana is doing data entry into a computer program which will interface with the Health Department.
Getting parents to take advantage of service.	Public awareness via media blitz.
Coordination and communication between representatives from the participating agencies.	A private public relations firm was hired to coordinate the campaign.

Key Partners/ Collaborators:

Humana Health Care
Rite Aid Pharmacies
Kiwanis Club

Accomplishments:

Successful collaboration with "big business" health entities. A broader awareness of what we have to offer as the public partner and its value.

Good publicity via major press conference.

Almost 100 children immunized after the first 7 days of the clinics.

Lessons Learned:

Openness to work with private and for profit groups may have long term community health benefits.

Partnerships to Address Community Violence

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Analysis of demographics, economic status, behaviors, health status. Community perceptions or health problems/needs. Assessment of provider reports regarding process and outcomes. Development of models. Promote compatible, integrated service system initiatives. Ombudsman services.	Family violence. Clergy & health connections. School & health connections. Increasing social support. Strategic planning. Building coalitions & partnerships. Building MCH data capacity.

Funding Sources:

Budget: $50,000

City/County/Local government funds.
Private source(s): Lincoln Medical Education Foundation
Other Federal funds.

Description:

In 1995, the first Comprehensive Domestic Violence Plan was released which called for the creation of a Family Violence Council and recommended a public education strategy directed through a Public Education Committee. It was the decision of the Committee to develop a domestic violence prevention and resource guide with specialized booklets targeting four groups: health care providers, clergy, employers and educators. In January 1996, more than 400 people were brought together for a conference sponsored by Community Health Partners of Lincoln-Lancaster County. The participants expressed overwhelming concern about the issue of domestic violence, ranking it as second in terms of importance, right after "affordability of health care". Shortly thereafter, the Family Violence Council was established with funding by a Prevention Block Grant. The council established an office separate from the "usual" agencies and sought broad based involvement of schools, clergy, policy, health care, and community advocates. The resource guide for clergy has been exceptionally well received by a variety of faith communities.

Objectives:

The Family Violence Council, with the assistance of the Health Promotion and Epidemiology Divisions of the Health Department, is evaluating the incidence of violence reported in the community through the analysis of E code data, utilization of shelters, calls to help lines and crime statistics.

Role of Local Health Department:

The Department has played the key role in convening Community Health Partners and the Domestic Violence Council, in working with the health care providers to obtain data, in drawing together materials for the resource guides, and developed and distributed a general resource guide, "Domestic Violence: A Public Health Education and Resource Guide." The Department is a community repository for E-coded injury data. Along with other community agencies, the Health Department provides support to the Family Violence Council.

Barriers Encountered:	Strategies to Overcome:
Turf wars between traditional agencies (e.g. law enforcement) and "new" community groups. Limited funding for coalition building. Inconsistent data gathering especially by health care providers.	Formed Family Violence Council housed on "neutral turf" Cooperatively sought and obtained grant funds. Hospitals and Health Department are working together to create standardized emergency room reporting forms.

Key Partners/ Collaborators:

Lincoln Police Department
Lancaster County Sheriff Office
Neighborhood Associations
Rape, Spouse Abuse Crises Center
Lincoln Council on Alcoholism and Drugs
Lincoln Public Schools
Planned Parenthood of Lincoln
Hospitals
Friendship Home
Clergy
Physicians

Accomplishments:

1. Establishment of the Family Violence Council and funding for an executive director.
2. Safe nights initiated at two schools and a Mad DADS Friday night gathering site.
3. Increased funding for women's shelter.
4. Creation of a community action group, "Men Against Domestic Violence".
5. Development and distribution of guidelines for clergy.

Lessons Learned:

Plan carefully to reduce turf issues especially with law enforcement and long standing domestic violence community advocates.

Seek the advice and consultation of model programs in other communities and then tailor to your community.

Seek the broadest possible community involvement.

Strive for a quality data base.

Childhood Immunizations in Public Housing (CIPH)

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:*

Community perceptions or health problems/needs.
Maternal, fetal/infant, child death reviews.
Special studies.
Newsletters, convening focus groups, advisory committees, networks.
Laboratory capacity.
Transportation & other access-enabling services.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.
Profiles of provider attitudes, knowledge & practices.

MCH Initiatives:

Immunization.
Other outreach activities.
Increasing access to Medicaid.
Building coalitions & partnerships.
Immunization tracking/recall.

Funding Sources:

Budget: $200,000

General state funds.
Other Federal funds.

Description:

The Pulaski County Health Department has formed a collaborative partnership with Public Housing Authorities (Little Rock, North Little Rock and Jacksonville) in the County to offer on-site immunizations to children who reside in Public Housing. The target age range is 1-36 months.

In addition, the Health Department will offer Well Child exams (including lead screening and WIC services) to participants. The Health Department will work with local community providers to assist clients in identifying a Primary Care Provider.

Objectives:

The establishment of an on-going plan for care for Housing Resident children which will assure them of a Medical Home placement and will offer on-going access to health screening, teaching and immunizations.

Role of Local Health Department:

The Health Departments Area VIII Administrative Office staff have taken the lead in this activity.
The Area VIII Manager is the Grant Director and works closely with the State Advisory Board and takes the lead in development of Sub-committees which are addressing implementation needs. The evaluation is being developed in conjunction with the State Health Department's Director of Health Statistics and the Grant Advisory Committee.

Barriers Encountered:	Strategies to Overcome:
Lack of understanding of the administrative and social culture of public housing and HUD. Recruitment of local medical providers to serve as medical home for participants.	Via routine Advisory and Partnership meetings, one-on-one contacts with housing residents and staff for planning, parenting classes and involving Housing Authority in staff hiring, orientation and training, design and process. Actively recruiting providers via Medicaid Outreach Coordinators office, mail-outs to providers offices, face-to-face discussion of program with providers, participation of providers on Grant transition team.

Key Partners/ Collaborators:

The Housing Authority Managers and Resident Council Representatives in Jacksonville, North Little Rock and Little Rock.
Baptist Health System
Children's Hospital
Family Service Agency
Housing and Urban Development Office
Medicaid - "Connect Care" Program

Accomplishments:

1. Has established a Grant Advisory Board composed of Health Department, housing authority residents, local hospitals, local HUD Office Representatives.
2. Recruit and hired staff to carry out Grant activities.
3. Has established timeliness for activities.
4. Utilizing space in Housing Authorities for service delivery.
5. Have formed cooperative agreements with local community doctors who have agreed to accept referral clients for Medical Home Placement.
6. Intake process completed.
7. Developing evaluation component.
8. Grant transition activity team has been formed utilizing community partners.

Lessons Learned:

Building new coalitions with traditional groups can be a sometimes "rocky" but very rewarding experience.
By increasing our awareness of the needs of public housing residents, our community providers can form a permanent system of interaction which will improve the health status and access to care for public housing residents in a culturally sensitive manner.
Keeping your hometown healthy.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Prenatal Provider Meeting "A Community Crisis"

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Prepare, publish, and distribute reports. Development of models.	Prenatal care. Expanding maternity services. Expanding private sector links.

Funding Sources:

Budget: $200

City/County/Local government funds.
Other:.
City Funds

Description:

In 1988, the California State Senate passed S.B. 176 allowing federal emergency Medi-Cal (Medicaid) to cover childbirth and State-funded prenatal and postpartum care for low-income women, including undocumented women. In August 1996 the Governor began procedures to eliminate this preventive program. Immigrants are disproportionately affected, since accepting full-scope Medi-Cal jeopardizes the status of both legal and illegal immigrants. In 1995, 53% of prenatal care in the City of Long Beach was paid by both full-scope and pregnancy-only Medi-Cal. Furthermore, 51.7% of all births were to mothers born outside the United States, including 32% to mothers born in Mexico. From our data, we cannot tell the immigration status of the mother. The State-funded prenatal care also covered women who could not meet the assets test under regular Medi-Cal.

In order to make the community aware, community physicians and staff were invited to a meeting to explain the impact of the loss of this funding. MCH data were presented to the practitioners for the first time. There were questions from the practitioners about welfare reform, immigration policies, and the mandated enrollment to Medi-Cal managed care from fee-for-service. This discussion led to further meetings with experts speaking on patient abandonment, advocating for prenatal care, and assisting clients with emergency disenrollment from Medic-Cal Managed Care. A fax tree was created to provide up-to-date information for OB-GYNs, Pediatricians, and Family Practitioners.

Objectives:

We had hoped to create an understanding of the needs of our MCH population in the community. We succeeded in clarifying issues to the community and enlisting their support for continued prenatal funding. However, funding may still be cut in November, 1997.

Role of Local Health Department:

The Health Department is the convener and major conduit of information. We plan to continue working with the community in offering information on policies that affect the health of our patients.

Barriers Encountered:	Strategies to Overcome:
The role of public health as community advocate was unfamiliar and uncomfortable for some. Compiling the fax list of clinicians was difficult and time-consuming.	We are still exploring our role as community advocates and as communicators of policy decisions. Administration offered clerical support, which helped.

Key Partners/ Collaborators:

Community physicians and their staff
Community-based organizations
MCH access
March of Dimes

Accomplishments:

Major accomplishments include the beginning of a dialogue between clinicians and public health. There has been a greater understanding of our roles and concerns. This dialogue led to the presentation of MCH data at OB M&M conference and pediatric grand round.

Lessons Learned:

Place your clinicians on fax lists. This is useful for urgent public health notices. Although a great deal of work was involved in getting it up, the system has greatly increased the visibility of the Health Department.

Teen Pregnancy

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:

MCH Initiatives:
Teen pregnancy.
Clergy & health connections.
School & health connections.
Building coalitions & partnerships.

Funding Sources:

Budget: Not reported.

City/County/Local government funds.
Other Federal funds.

Description:

A regional effort to address the issue of teen pregnancy and offer ways to prevent early child-bearing. The project's four components include:

1. Regional advisory board of elected officials, clergy, business leaders, school officials, and most importantly, teens.
2. In-depth focus groups with more than 200 teens, parents and service providers. The results of the University of Louisville focus groups were eye-opening to many opinion leaders.
3. Increase the number of schools using the sexuality curricula Postponing Sexual Involvement and Reducing the Risk.
4. Expand non-school hours programs and community-based education.
5. Develop and launch public education/media campaign.

Objectives:

Create better community awareness of the problems associated with teen pregnancy.
Increase the percentage of students exposed to PSI and RTR.
Continue non-school hour programming through Planned Parenthood's peer education program.

Role of Local Health Department:

The health department staffed the project and organized much of the activities listed. A part-time community organizer with a background in women's health issues served as the main contact.

Barriers Encountered:
Inter-agency lack of information.
Interest in issue.
Funding.

Strategies to Overcome:
Regular Steering Committee meetings between those involved in teen pregnancy prevention.
High profile advisory board.
Coordination between groups applying for grants.

Key Partners/ Collaborators:

Public schools, seven counties services (the mental health agency for region), Louisville Youth Alliance, Family and Children's Agency, Home of the Innocents Teen Parenting Program, and Planned Parenthood.

Accomplishments:

Community buy-in to efforts to prevent pregnancies. Number of Jefferson County students exposed to RTR tripled, from 1300 to 3988. Number of middle schools using PSI increased from seven to twelve. And equally encouraging, twelve elementary schools have applied to use the PSI curriculum.

Lessons Learned:

Get buy-in from key community leaders. Delegate one person to serve as contact/clearinghouse. Build and document the case for additional programs before you start to seriously organize.

South Madison Health and Family Center Harambee (Swahili for "Pulling Together")

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Replicated Elsewhere?
No

Updated Profile?
Yes. 1993

Essential MCH Functions:

Hotlines, print materials, media campaigns.
Special studies.
Newsletters, convening focus groups, advisory committees, networks.
Ombudsman services.
Provide infrastructure/capacity for MCH functions.
Laboratory capacity.
Provide outreach services.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.

MCH Initiatives:

Overcoming cultural barriers.
Reducing transportation barriers.
Expanding private sector links.
One-stop shopping locations.
Increasing social support.
Building coalitions & partnerships.

Funding Sources:

Budget: $363,528

City/County/Local government funds.
Private source(s).
Other Federal funds.
Third party reimbursement (Medicaid, insurance)

Description:

The South Madison Health and Family Center (SMHFC-H) represents a community pulling together. This unique project brings together public and private nonprofit agencies to provide comprehensive child development, family support, education, and health care services in the community of South Madison. Center partners work with the neighborhood and with each other to design and provide services that meet the needs of the community and build on its strengths.

South Madison was deemed an excellent location for this project because of the community's strengths and commitment of the neighborhood. The project was developed to enlist active community participation in addressing identified health care, family support and educational needs. As a community-wide resource for health and education that promotes human growth and development, SMHFC-H is an anchor for the South Madison community - a place that creates opportunities for young children, their families, and the whole community. In addition to a full range of health care services, a variety of child and family support services are available including a Family Resource Center, GED classes, early childhood and parent education opportunities, library, and referral network.

Objectives:

The mission of SMHFC-H is to promote community-based, culturally sensitive, comprehensive and coordinated health and educational services to serve, promote and support healthy independent families and individuals. Its goals are to provide: 1) a partnership that responds to community needs by including neighborhood residents in planning and governance; 2) systems and services coordinated among different providers; 3) transportation, translation, and advocacy services that will improve access for all community residents; and, 4) a place where providers and participants learn from each other.

While SMHFC-H concentrates on services for young children and their families, its library services, preventive and primary health care and education services are available to every age group. An evaluation conducted by an independent consultant was completed in October 1997.

Role of Local Health Department:

The Madison Department of Public Health provided initial leadership in the creation of the center and continues to be the lead agency. The CISS Grant was awarded to the department and center staff are city employees.

Space for the center is leased by the City of Madison, which continues to be in charge of building management. The 10-year lease with 10-year renewal option provides stability for the location and existence of the center. In addition, the city financially supports much of the common space in the facility and rents program space to individual agencies.

Barriers Encountered:	Strategies to Overcome:
Financial barriers/sustainability remain the greatest challenge. A CISS Grant provided funding for staff and programming to assist the agencies in their collaborative efforts until 9/30/97. Also challenging is having so many partner agencies with different missions, funding sources, strengths and weaknesses attempting to provide coordinated and integrated services.	Since the CISS Grant ended on 9/30/97, the City of Madison has provided funding for center staff and supplies. The Board of Directors of the center funds transportation and translation services. Frequent meetings of partner agencies and staff retreats offer opportunities for getting to know each other and learning each other's agencies.

Key Partners/ Collaborators:

Partner agencies who provide services at the center include the Dane County Parent Council (Head Start), the Early Childhood Family Enhancement Center, Madison Community Health Center, Madison Public Library, University of Wisconsin Hospitals and Clinics, UW Nursing and Medical Schools, Madison and Dane County Departments of Public Health (including WIC) and Planned Parenthood of Wisconsin, Inc. The agencies maintain individual identities at the center, providing unified services whenever possible and remain diversified where necessary for improved quality and choice for the client. The center will pursue partnership status with the Dane County Dental Society's Harambee Dental Clinic.

In addition, there is a community partnership with the Junior League of Madison, which donated $50,000 initially and made a 4 year commitment to provision of initiatives for the center. The center is also the beneficiary of funds generated by the Madison Marathon.

Accomplishments:

Since described in the 1993 CityMatCH Urban MCH Profile, the SMHFC-H has expanded from the co-location of agencies in a small building to a 35,000 square foot renovated bowling alley (10 times the former space) allowing for the better integration of existing services that can be provided simultaneously, as well as the addition of services - all of which have contributed to the center's capacity to serve greater numbers of families. Regular interdisciplinary team meetings are held and the Center has become a training site for many professionals, including nursing, medical, social work, education, nutrition, and librarian students who learn to work as part of the team. A common record is used by all health providers. Center staff reflects the racial and ethnic diversity of the community and the brochure is printed in both English and Spanish. Translation, transportation and outreach services are currently provided. The Board of Directors includes neighborhood and provider representatives, as well as members from the community at large. A center-wide effort coordinates the services of over 100 volunteers. The library, which was in jeopardy of being closed, increased usage by over 15% in the first 2 months the new center was opened. The project was a Kellogg Foundation Community Care Network Demonstration Program finalist.

Lessons Learned:

The greatest lesson learned is that the price of collaboration is time, and that commitment must be ongoing. In addition, policies, procedures and written directions are very important and need to be utilized consistently.

BEST COPY AVAILABLE

Project Screen (Breast and Cervical Cancer Screening Program)

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Replicated Elsewhere?
Yes. In some counties of the State of Florida.

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Laboratory capacity. Identify high-risk/hard-to-reach populations.	Breast/cervical cancer. Overcoming cultural barriers. Reducing transportation barriers. Expanding private sector links. Mobile clinics for outreach. Other outreach activities.

Funding Sources:

Budget: $237,187

Other Federal funds.

Description:

Project SCREEN is a Breast and Cervical Cancer Screening Program including education, follow-up and referral to treatment services. Project SCREEN of the Miami-Dade County Department of Health works in partnership with the University of Miami/Sylvester Comprehensive Cancer Center Early Detection Program, the YWCA ENCORE plus program and various community organizations to reduce the mortality rate from breast and cervical cancer among Dade County under served women. The project targets low income women with no insurance. The priority population for breast screening is low income women 50 years and over. The priority population for cervical cancer screening is low income women 40 years and over. The project started in October 1995.

Objectives:

The goal of the project is to reduce mortality from late stage of breast and cervical cancer by early detection and education outreach. The outcomes measures are the number of women from the priority population screened for breast and cervical cancer. The objective of the project is to increase by 1200 the number of medically under served women 40 years and older who have received a pap, a pelvic exam, a clinical breast exam and to increase by 1200 the number of screening mammograms in the eligible population.

Role of Local Health Department:

The application for the grant was prepared by the Office of Health Promotion of the Miami-Dade County Department of Health. Planning, programming, budgeting, implementation of the program and evaluation is the responsibility of the Department of Health.

Barriers Encountered:	**Strategies to Overcome:**
The rate of broken appointments is very high. Some women have been scheduled more than twice. At all times we must have staff who speak Spanish, English, French and Creole.	We educate the women on the importance of the screening. Assist them with transportation and baby-sitting services. We recruited bilingual staff and organized their schedules in order to guarantee language capacity.

Key Partners/ Collaborators:

Jackson Memorial Hospital, a tertiary care hospital and clinics provides the diagnostic and treatment services. A mobile mammography van from the University of Miami Early Detection Program provides the screening mammograms. A network of primary care clinics and Community Health Centers provide the pap test, the pelvic exam, and the clinical breast exam. A network of social organizations and the media handle the outreach needs of the project. The YWCA ENCORE plus and the clinics are responsible for the education of the women targeted by the project.

Accomplishments:

During the first year of operation 800 women received screening for breast and cervical cancer. For the year 1996 the project staff processed 1200 requests for services and scheduled over 870 women for services. Partners from various organizations in the community have conducted extensive outreach to the various ethnic groups of Miami-Dade County (Haitians, Hispanics, African American, Caribbean and White). As of June 30, 1997 over 472 women have received a pap test, a pelvic exam and a clinical breast exam, and over 245 mammograms were provided to the priority populations targeted by the project.

Lessons Learned:

The availability of funding and a network of providers in the community do not guarantee the expected outcomes. To provide screening services to minority populations it takes the commitment of all the key players in the community and a tremendous amount of education of the targeted population.

School Health Services

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:

- Develop tools standardizing data collection, analysis, reporting
- Analysis of demographics, economic status, behaviors, health status.
- Special studies.
- Develop & promote MCH agenda & YR2000 National Objectives.
- Newsletters, convening focus groups, advisory committees, networks.
- Promote compatible, integrated service system initiatives.
- Provide infrastructure/capacity for MCH functions.
- Identify high-risk/hard-to-reach populations.
- Pediatric risk adjustment methods & payment mechanisms.

MCH Initiatives:

- Expanded child health services.
- School-linked/based services.
- School-linked/based services.
- Expanding private sector links.
- School & health connections.
- Building coalitions & partnerships.

Funding Sources:

Budget: Not reported.

City/County/Local government funds.

Description:

Historically, school health services have been provided by public health nurses of the City Health Department to all public, parochial and private schools. Within the public health model, public health nurses provided school health services in addition to the home visiting and clinic services provided in their districts. The number of schools assigned averaged three, with approximately 2-4 hours per week spent at each school.

For the past decade, the school population has shifted to one that is more economically disadvantaged, and has multiple physical and mental health needs. The resources of the health department were not adequate to meet these changing needs.

In 1991, the Bureau of Public Health Services appointed an PHN Supervisor as liaison to the Superintendent's office for the purpose of strengthening the school health program. Coordination resulted in teacher in services in communicable disease recognition and control, improvement in the process of hearing screening and referral, and recommendations for strengthening school policies and procedures related to health.

This early collaboration expanded to an advisory capacity to the Health Curriculum Specialist in the public school system in developing a comprehensive school health model for the system. This continues to this date.

Objectives:

The objectives of the collaboration are to address identified health needs of students, improve the attendance and performance in school, increase student and family awareness of health and wellness issues and resources available, increase access to primary health services and ultimately improve the health status of the students and their families. The evaluation of outcomes has not been done to date, but is being planned.

Role of Local Health Department:

The Department is directly involved in all phases of the collaborative initiative. It is expanding to include health systems in the City in developing different models of delivery for clusters of schools in the district.

Barriers Encountered:	**Strategies to Overcome:**
Misperception of the role of the school public health nurse. The role of managed care in school health.	Defining the role for school staff and other professionals through in service. Inviting health systems to the table.

Key Partners/ Collaborators:

Milwaukee Public Schools, University of Wisconsin-Milwaukee School of Nursing, Marquette University College of Nursing, Medical College of Wisconsin-Pediatrics, and Children's Hospital of Wisconsin.

Accomplishments:

A needs assessment was completed by both school nurses and social workers in the 1995-96 school year identifying the top services needed and the health issues contributing to absence and ability to learn. One elementary school purchased an increase in hours for the nurse to support that position as part time. That school then became the basis for a further collaboration with UWM School of Nursing and Riverwest Community groups, to develop a proposal for funding of a nursing center at the school, which started this year. Consultation was provided for the development of policies, procedures and training of school staff in the administration of medications to students at school. Health Teams were encouraged to be formed at the school to collaborate with the school nurse assigned in completing individual school needs assessments. Increased participation of schools of nursing in school settings has also occurred.

Lessons Learned:

Collaboration needs vision, leadership and consistency of purpose to accomplish the goals and objectives that will benefit the community. It is worth all the work.

School health provides an environment and an opportunity that allows for and encourages initiation of essential MCH functions to a high risk population.

BEST COPY AVAILABLE

Redefining MCH: Focus on Core Public Health Functions

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Analysis of demographics, economic status, behaviors, health status. Assessment of provider reports regarding process and outcomes. Prepare, publish, and distribute reports. Newsletters, convening focus groups, advisory committees, networks. Promote compatible, integrated service system initiatives. Ombudsman services. Support of continuing education. Laboratory capacity. Identify alternative resources to expand system capacity.	Expanding private sector links. Reshaping urban MCH. Building coalitions & partnerships.

Funding Sources:

Budget: $8.2 million

City/County/Local government funds.
General state funds.
MCH block grant funds.

Description:

The Minneapolis Department of Health and Family Support has reorganized during 1996-97 to focus on the core functions of public health: assessment, policy and advocacy, and assurance. During this year long restructuring (still in progress), direct MCH services previously provided through MDHFS have now been contracted to a network of nonprofit community clinics and other community agencies. The restructured department provides oversight and management of these contracts, and advocates for the health of Minneapolis residents.

Objectives:

One major result of the restructuring has been a staff reduction of over 50% as services were contracted out or programs moved to other city or county departments. New staff are being hired with skills in providing the core functions. The assessment unity is hiring biostatisticians, program evaluators, and epidemiologists to collect, analyze, and interpret MCH data. Policy and advocacy staff are working with legislators, city council members, and decision makers in various organizations and community agencies to include MCH concerns in their policy agendas. The assurance function is heavily invested in ensuring that needed MCH services are available via the new contracts with nonprofit and private providers in the community.

As a first outcome measure following this transition, MDHFS staff surveyed their previous clients to help assess their placement with new clinics or providers. While over 95% were contacted at the time the clinics closed, only 30% could be contacted for a follow-up student of these clients 10 months later.

Role of Local Health Department:

At the direction of the Mayor, City Council, and with little planning or impact analysis, the Commissioner of Health implemented the restructuring. In the process of restructuring, many human resource professionals with the City, as well as professionals from the community, have assisted in the redesign of the administrative structure, development of a new mission and vision, and the delineation of goals and objectives for the new department. On-going evaluation of the restructure process is needed, as well as methods for evaluating the effectiveness of the assessment, policy/advocacy, and assurance functions.

Barriers Encountered:	Strategies to Overcome:
Resistance to change is almost always a factor in any major organizational restructuring. Tradition in local health departments can be a deeply held cultural value, passed down through years among the staff. With the new emphasis on core functions, staff must learn to work beyond the boundaries of their professional training. One unfortunate result of the restructuring is that many external agency staff believe that the department no longer exists.	Seminars, classes and workshops have been presented to encourage staff to explore feelings of grief and anger regarding the changes, as well as to provide skills in computer use, grant writing, contract management, and team building. Through the development of a marketing plan to inform other agencies and the public of our new role, and through increased visibility of staff (particularly policy and advocacy staff) in driving department priorities.

Key Partners/ Collaborators:

Key partners include the Mayor, City Council members, and a variety of public and private entities with whom activities have been planned and contracts developed. These include the county health department, community clinics, visiting nurses association, and the school district.

Accomplishments:

1. Client access for MCH services has improved dramatically. Previously, clients were limited to 24 hours in several downtown locations, with no weekend and few evening hours available. Now under the contract with the nonprofit community clinics, clients have access to 9 different locations throughout the city, and varying evening and weekend hours. Most of the contracted clinics are full-spectrum primary care clinics, so clients are able to access MCH services as well as choose a "medical home."
2. With the discontinuation of most direct services, the department is now able to focus time and resources in the areas of assessment and policy/advocacy. Examples of significant projects for the assessment unit include city and county wide surveys of 10,000 households of the health status of families and children. Future policy and assurance activities will be directed by the outcomes of these studies. Significant time is also being spent on improving the contract development, monitoring, and evaluating process.

Lessons Learned:

This is better undertaken as a planned process. Time, energy and resources need to be used to assist staff and clients to understand, or at least grapple with this change. Plan to expend a large amount of effort on informing staff and agencies you work with about the true nature of public health and the definition of the core functions. Hire a risk taker and learn to live with uncertainty and constant change as the process evolves.

Demonstration Project in Collaboration with Families Achieving Independence in Montana

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Replicated Elsewhere?
No

Updated Profile?
Yes. 1996

Essential MCH Functions:
Special studies.
Newsletters, convening focus groups, advisory committees, networks.
Promote compatible, integrated service system initiatives.
Laboratory capacity.
Transportation & other access-enabling services.
Monitor enrollment practices for ease of use.
Profiles of provider attitudes, knowledge & practices.

MCH Initiatives:
EPSDT/screenings.
Expanding private sector links.
Case coordination.
Increasing access to Medicaid.
Building coalitions & partnerships.

Funding Sources:

Budget: $45,000

City/County/Local government funds.
MCH block grant funds.
Third party reimbursement (Medicaid, insurance)

Description:

MCCHD initiated a demonstration project in collaboration with Families Achieving Independence in Montana (FAIM), the state welfare reform program. A goal of the project was to enhance the health status of families in FAIM/Medicaid. FAIM case coordinators refer clients to the onsite PHN Consultant for assessment education that focuses on EPSDT guidelines and family health needs, and referral/advocacy. During the first nine months of the project the FAIM Nurse Consultant has:
1) visited physician offices for education related to the project and clarification of EPSDT standards and FAIM client compliance requirements;
2) used a variety of tools to identify health risks, infant/child development, barriers to care and access to resources;
3) provided education and arranged for access to a medical home, Social Security and counseling; 4) identified parental problems that prevent compliance;
5) tracked client referrals to identify client follow through and agency response.

A survey of client and FAIM case worker was done to determine satisfaction with the service, most and least valuable components of the nurse's interventions and to garner ideas for improvement.

Objectives:

1. Collaboration with FAIM case workers in care plan development - to include health needs and plans.
2. Access to primary and preventive health care for AFDC/Medicaid enrolled children.
3. Parental education regarding childhood preventive health needs and utilization of the health care system.
4. Identification and referral of children with special needs.
5. Development of a model to be replicated at other public health/human services sites in Montana.

Role of Local Health Department:

MCCHD will continue the demonstration project in collaboration with partners at the state and local levels. Positive responses regarding the project activities have been received through a client/case worker survey, however, a more formal evaluation is needed and will be planned/conducted by MCCHD.

Barriers Encountered:	Strategies to Overcome:
Lack of understanding by medical providers requirements regarding EPSDT/Immunizations. FAIM case workers understanding of appropriate referrals to the FAIM nurse. Lack of communication with the FAIM nurse when other agencies are involved in care plan. Schedules of appointments with FAIM nurse not sensitive to client issues of transportation and work issues.	Continue to educate and work with health care providers. Continue to collaborate and provide liaison with case workers and extended agencies. Problem solve with OPA to enhance access to FAIM nurse.

Key Partners/ Collaborators:

Director of Montana Medicaid Program, Director of Montana Family and Community Health Bureau (Title V), Director of County Office of Public Assistance, Missoula City-County Health Department Health Services Director, and other members of the Local Welfare Reform Task Force.

Accomplishments:

See outcomes and objectives.

Lessons Learned:

Public health has a role in welfare reform and must continue to advocate for clients and develop systems that assure access and assess impacts on health.
Communication of PHN and FAIM Coordinator has been greatly improved.
Clients who are still on FAIM are more multi-barriered than ever anticipated and increasingly challenged than welfare can provide for.
Better identification of multi-barriered families needed by the FAIM coordinators in order to prevent unnecessary failures in expectations.

West Modesto/King Kennedy Neighborhood Collaborative

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Replicated Elsewhere?
No

Updated Profile?
Yes. 1996

Essential MCH Functions:

Hotlines, print materials, media campaigns.
Culturally appropriate health education materials/programs.
Develop & promote MCH agenda & YR2000 National Objectives.
Laboratory capacity.
Provide outreach services.
Transportation & other access-enabling services.

MCH Initiatives:

School-linked/based services.
Teen pregnancy.
Overcoming cultural barriers.
Clergy & health connections.
Other outreach activities.
Increasing social support.
Strategic planning.
Building coalitions & partnerships.

Funding Sources:

Budget: $300,000

City/County/Local government funds.
General state funds.
MCH block grant funds.
Private source(s): Sierra Health Foundation, Omega Nu

Description:

The Minority Health Coalition started in 1991 to identify health issues within the multicultural community in Stanislaus County. The work performed by the Coalition led to the establishment of the West Modesto/King Kennedy Neighborhood Collaborative in 1995. The Collaborative has a diverse group of members, i.e. Cambodian, Hmong, Laotian, African-American and Hispanic. The total membership of the Collaborative is now approximately 252, and has grown to include Caucasians and American Indians.

In 1995, the Collaborative completed a community assessment and entered a Strategic Planning phase to address concerns of the community around health and teen pregnancy and education issues, employment, safety, gang involvement, after-school activities and child care. The Collaborative members engaged in the following activities during the Strategic Planning: 1) cementing partnerships with the local business community; 2) participating in planning and response to the State's Community Challenge Grant; 3) expanding activities for Fantastic Family Friday; 4) forming an Environmental Committee; 5) building a Multicultural Family Resource Center; 6) partnering with Modesto City Schools on a Healthy Start Implementation Grant.

Objectives:

1) Children with be involved in socially positive activities by increasing the number of children -0-8 enrolled in Collaborative recreation programs who have high self-esteem as measured by the Cooper-Smith Self-Esteem Inventory and decreasing the number of school expulsions and suspensions for children 6-8 enrolled in activities.
2) Families will be more involved in child's/children's total development by increasing the number of parents involved in PTA as measured by school records.
3) Children will be well-educated by decreasing the absenteeism for children K-8 as measured by attendance records.
4) Parents will be more informed about their child's/children's academic progress and the school's procedures and activities by increasing the number of parents (children enrolled in Collaborative activities) who answer that they assist their children with homework as measured by family functioning assessment tool.
5) Families will be more involved in neighborhood activities by increasing the number of families who volunteer for neighborhood activities as measured by program leaders.

Role of Local Health Department:

The Health Department's Maternal Child Health Director serves as the Technical Advisory and Coordinator for the Project. The Director and various staff has assisted with assessment, strategic planning and developing an implementation plan. The Health Department has been able to assist in engaging the California State University/Stanislaus as the evaluators, take the lead in writing for the various grants that will support the Collaborative mission and plans to address community concerns. The Health Department has been instrumental in not only preparing community members, but contributing to the employment of five (5) over this last year.

Barriers Encountered:	**Strategies to Overcome:**
Trying to address so many areas at the same time. Re-engaging the Spanish population after the death of the Community Developer. Maintaining the diverse leadership.	Partnering with agencies and continuing to build the Collaborative membership. Recruiting bilingual community members who are able to speak the language as well as represent the culture. Trying to hire community members for jobs, as appropriate.

Key Partners/ Collaborators:

Modesto City Schools -- Mark Twin Jr. High, Pearson Elementary, Central Office-Assistant Superintendent, Franklin, James Marshall, Modesto High; Modesto City Parks and Recreation Department; Modesto City Police; Habitat for Humanity; Omega Nu; J.D. Grothe Architects; Center for Human Services; Girl Scouts; Boy Scouts; Sierra Health Foundation; area ministers; The West Modesto Community; and local businesses.

Accomplishments:

1) Collaborated with Board of Supervisors and Agency Director to promote community forums on health needs and changes in the Health Care System.
2) Developed Student/Family Advocacy Committee to serve as liaison between parents and school.
3) Developed and implemented parenting classes for Asian parents.
4) Developed curriculum and training in Hmong and Laotian for children to learn these languages.
5) Engaged local government agencies, religious community and businesses in planning for a "Multicultural Family Resource Center."
6) Engaged religious community in active participation with the Collaborative.
7) Established relationships with Modesto City Schools District Office and principals of the target schools.
8) Host Annual Community Picnic serving over 600 people.
9) Increased health awareness in the community.
10) Participated with a local radio station to provide back-to-school clothing for a child from one of the target area schools.
11) With Modesto City Parks and Recreation, developed weekly activities for youths 0-8.
12) Participated in development and implementation of the "Wellness Teen Pregnancy Initiative," the State's Challenge Grant and the Healthy Start Grant for Mark Twain Jr. High to address issues identified in our Child Health Profile.

Lessons Learned:

There's a wealth of unidentified people with talent and skills waiting to be unearthed. The community has the capacity to resolve a lot of the issues they are faced with, but often just need the encouragement, the technical assistance and tangible resources to assist them.

It is extremely difficult for agencies to not "direct" a community or think they "know what's best." It is important that we allow them space to grow and experiment at their own pace. It is often slower to bring a community along in planning and decision making, but the benefits far outweigh the problems because, after all - our job is "to teach them how to fish."

Improving Access to Care

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Monitor MCO marketing practices. Support of continuing education.	Reducing transportation barriers. One-stop shopping locations.

Funding Sources:

Budget: Unknown

City/County/Local government funds.
Private source(s): Private donations and Baptist Health

Description:

A collaborative effort by the City of Montgomery, Baptist Hospital, Alabama National Guard and the Alabama Department of Public Health was initiated to increase access to care for people who might not have access to health care. The project was called Operation Care and it was designed to assist the medically under served citizens of Montgomery gain access to appropriate medical services. It was a community benefit project conducted during May 1997 and it used hundreds of volunteers to provide free medical and social services to over 1,500 uninsured and underinsured citizens of Montgomery.

Objectives:

The expected results were to provide treatment services along with educating and involving participants in the primary care facilities available in the Montgomery area.

Role of Local Health Department:

Work with health care delivery system in the community to plan, implement and evaluate the effectiveness of the project.

Barriers Encountered:	**Strategies to Overcome:**
Transportation	Free transportation to and from provider site.

Key Partners/ Collaborators:

State central office administration along with count staff worked closely to make sure all aspects of public health services were provided as necessary. City of Montgomery and Alabama National Guard.

Accomplishments:

Community involvement and collaboration among health care providers and social service organizations to increase access to all citizens.

Lessons Learned:

Collaboration with other health care providers in the community can get more accomplished in less time. For example, Operation Care treated more than 1,500 people in two days; some of whom indicated they had never been to a doctor.

Davidson County Child Death Review Team

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Replicated Elsewhere?
Yes. Statewide

Updated Profile?
Yes. 1996

Essential MCH Functions:	**MCH Initiatives**:
Develop tools standardizing data collection, analysis, reporting Environmental assessments. Assessment of provider reports regarding process and outcomes.	Infant/child death review.

Funding Sources:

Budget:

Each agency donates their time and efforts. The program has no direct funding source.

Description:

The Child Death Review Team was started by executive order of Mayor Bredesen on January 5, 1994. Members include administrators or their appointed representative of public and private agencies that deal with Davidson County children at risk of abuse and neglect. The team members represent various health, social services and law enforcement agencies. Birth and death data is obtained from the Davidson County Vital Records Department and sent to all members prior to the meeting. Members then bring their records and share relevant data about the child and family that may have impacted that cause of death.

The Team:
Identifies the cause of death for Davidson County residents dying within the state who are under 18 years of age;
Identifies the circumstances surrounding and contributing to the death, especially in those cases that were preventable;
Identifies where agencies can make internal changes in their policies and procedures to better protect children;
Identifies needed changes in legislation, policy or practice and makes recommendations to the appropriate governing body.

Objectives:

The expected outcomes of this activity are:
1) Internal agency policies would change to better serve the children. This has been seen by an openness of administrators to discuss their policies and make changes. Interagency assistance has been offered in providing education and expertise to fellow agencies.
2) Policy changes will bring about a decrease in child deaths.
3) Child deaths have decreased from 123 in 1994, to 116 in 1995 and to 105 in 1996.

Role of Local Health Department:

The Director of Health serves as the chair of this team for Davidson County. The health department provides the staff support to the teams, including meeting site, all communications with team members, data gathering and publishing the annual report and dissemination of the same.

In 1995, the Davidson County Team provided information, training and support to other counties as they prepared to start their Child Death Review Teams.

With the inception of a statewide Child Death Review Team in 1996, the Director of Health serves on that Team. They look at state trends in data obtained from the local and regional teams.

Barriers Encountered:	Strategies to Overcome:
Getting individual organizations to work together. Developing a database that will allow both internal agencies and policy makes the data needed to identify problem areas and address needed changes to legislative policies.	Much of the first year centered around team members getting to know each other, building trust and learning to support each other in order to bring about positive changes to benefit the county's children. As new trends began to surface we were able to add to the database in order to look at specific trends that may be indirectly contributing to the death of our children.

Key Partners/ Collaborators:

Key partners have included: Metropolitan Policy Department (3 representatives), local pediatricians (4 representatives), mental health (1 representative), Department of Children Services (2 representatives), Social Services Agencies (2 representatives), legal system (2 representatives), and Clinic for Diagnosing Abused Children (2 representatives).

Accomplishments:

Team members developed a trusting working relationship which allows them to examine and candidly discuss their own internal structures and practices that affect children and their families.

With the completion of the third year of data collection we were able to begin to look at trends and identify the leading causes and circumstances surrounding child deaths in the county. As we build more information on these deaths, existing programs and new initiatives can better focus on preventing deaths in specific groups of children and/or areas of town where high death rates are common. Child deaths have decreased for three consecutive years.

Lessons Learned:

Team building at the start pays off with better inter-agency understanding and cooperative

A good data gathering system allows the team to begin to look at trends. With the cooperation of many of the leading agencies dealing with children in Davidson County, it will become possible for the group to share their expertise in developing internal programs to change these trends and to make recommendations to the appropriate legislative bodies where policy changes are needed.

TennCare Enrollment

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Monitor enrollment practices for ease of use. Managed Care model contract & access issues.	Increasing access to Medicaid. Other outreach activities.

Funding Sources:

Budget: $275,540

Other: Funding from Bureau of TennCare through the State Department of Health

Description:

The State of Tennessee under waiver from HCFA developed a TennCare insurance program that placed all former Medicaid recipients and also enrolled about 400,000 uninsured residents into one of several MCO plans. Due to reaching capacity, enrollment was closed January 1995 to the uninsured segment but remained open for those approved by DHS as having met Medicaid guidelines. By executive order the governor opened enrollment to children without access to insurance effective April 1, 1997. A joint venture was started between the Bureau of TennCare and the Department of Health whereby the local health departments would assist in the enrollment process thus speeding up the process. Health department staff were given access to applicant TennCare files and after verifying information and making needed corrections to applications are able to process those applications. Applicants now come to the local health department to be enrolled in TennCare.

Objectives:

The expected outcome is that 50% of the estimated 6,000 eligible children will be enrolled during the first year. Outreach was provided through community meetings and public service announcements prior to the start of the program. Outcomes are measured by the number of children enrolled out of the estimated pool of eligible children in each county.

Role of Local Health Department:

Davidson County Health Department staff are involved in the implementation of the Enrollment Program. Staff members provide suggestions and input at Statewide TennCare State Health Department meetings.

Internally, we evaluate the program based on numbers enrolled and by auditing compliance with State regulations.

Barriers Encountered:	**Strategies to Overcome:**
Need for training for local staff in TennCare process. Speed with which the program was set up.	Ongoing training was provided on an individual and group basis to update ever changing policies and procedures. A need for internal audit was identified to ensure that problems were identified and addressed at the local level.

Key Partners/ Collaborators:

Key partners are the State Departments of Health and TennCare.

Accomplishments:

1,486 children have been enrolled since the inception of the program on April 1, 1997. The linkage between the local health department is a help desk maintained by the State Department of Health and the Bureau of TennCare. This has greatly assisted in the problem solving process and improvement of the process.

The enrollment process has been streamlined and the time for enrollment shortened.

Advocacy groups are pleased that the local health departments are enrollment sites.

Lessons Learned:

We have learned that it is possible for three government entities (a local health department, Department of TennCare, State Department of Health) to work together to resolve problems efficiently.

Shots for Tots Mardi Gras Initiative

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Not reported	Not reported

Funding Sources:

Budget: $15,500

Childhood Immunization Initiatives Federal Grant

Description:

"Shots for Tots" is Louisiana's Infant Immunization Initiative. Between 1992 and 1996 immunization rates in the city of New Orleans increased from 49% to 76% of two year old children through this comprehensive program. However, in 1996 it was felt that continuous new strategies were needed to bring the coverage from 76% to 90% by the year 2000. It was thought that we needed a creative, new way to reach people with knowledge of the importance of early immunizations and how to get their children vaccinated. One of these strategies became known as the "Shots for Tots Mardi Gras Initiative".

The City Health Department decided to involve local businesses and community groups in the creation of a Mardi Gras float which would distribute immunization schedules and educational materials in true New Orleans form: on the side of cups, buttons, beads, and pamphlets thrown from a Shots for Tots Mardi Gras float. The activity was a true community project, mobilizing in an effort to motivate parents to get their children immunized. The effort was such a success that plans are already underway to make this an annual event.

Objectives:

Expected Outcomes: increased public awareness of the need for timely immunizations and their free availability, increased number of children vaccinated. Measures: number of cups, buttons, beads and pamphlets disseminated; city immunization coverage rates by age 2 years as assessed by CDC CASA estimates

Role of Local Health Department:

This initiative was planned and implemented completely by the health department using donations from private businesses, community groups, the Childhood Immunization Initiative federal grant (for educational materials thrown), prison labor, and support from family and friends. Immunizations rates are assessed by CDC using CASA software.

Barriers Encountered:	**Strategies to Overcome:**
Financial barriers: Soliciting businesses for monetary donations, services and products such as nails, lumber, flatbed truck and truck driver, food, paint, latrine on board, party for donors, etc. Manpower to construct float: Prison labor was used to construct decorations; volunteers, family and friends of employees helped in float construction. Getting a parade spot (advertising is banned on all Mardi Gras floats): "ask and ye shall receive"; permission was granted because it "was a good cause"	

Key Partners/ Collaborators:

Private businesses such as bakeries, hardware stores, truck company, restaurants, etc.
Community clubs such as rotary.
Prison workers.
City Park - donated a free party for donors ("Lundy Gras Party")
Crescent City Truck Parade - granted parade spot

Accomplishments:

This activity resulted in the distribution of 27,000 cups with the Shots for Tots phone number and immunization scheduled, 1000 pamphlets, 1000 beads and 500 program buttons. Since the activity was held in March 1997, it was not felt that the full impact of the intervention could be assessed by looking at 1997 immunization coverage rates, which are collected between June 1996 and June 1997. However, it is anticipated that if this becomes a yearly activity it will have a significant impact in reaching the goal of 90% coverage by the year 2000.

This activity also drew the support of 34 small businesses and community groups with total contributions worth more than $10,000. One of the most important accomplishments of our department was receiving such visible and generous support from the community in an effort to get our children vaccinated.

Lessons Learned:

Successful community participation was achieved by linking this health initiative to an already popular event that everyone wanted to take part in, i.e. Mardi Gras. In another city this may be a rodeo, a state fair, a popular parade, cherry blossom festival, etc. Linking childhood vaccinations with a Mardi Gras float and using Mardi Gras throws to disseminate vaccination schedules and information generated incredible community involvement and support which we had not anticipated. While initially this seems like an enormous undertaking, the support of community groups and businesses made this a highly successful event.

BEST COPY AVAILABLE

Open Airways for Schools

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Maternal, fetal/infant, child death reviews. Culturally appropriate health education materials/programs. Develop & promote MCH agenda & YR2000 National Objectives. Provide infrastructure/capacity for MCH functions. Support of continuing education.	Expanded child health services. School-linked/based services. School & health connections. Staff training. Building coalitions & partnerships.

Funding Sources:

Budget: $87,000

City/County/Local government funds.
Private source(s): Glaxo Wellcome donated $87,000 to the ALA of NY

Description:

Asthma is a significant public health condition which has a tremendous negative impact on school-aged children. Through a unique public-private partnership between the New York City Department of Health (DOH), Bureau of School Health (BSH), the New York City Board of Education (BOE), the American Lung Association (ALA), and Glaxo Wellcome, *Open Airways for Schools (OAS).* OAS is an American Lung Association asthma-educational program designed to teach children, aged 8-11, how to detect the warning signs of asthma and manage their asthma. Using a public health model, the program involves an interactive approach, utilizing group discussions, stories, games, and role-play to promote children's active involvement in the learning process. School health nurses were trained by ALA asthma experts and developed skills to implement the OAS curriculum as part of their public health nursing tasks in the schools. Based on the success of this pilot and the expanded presence of DOH nurses in all elementary schools in the City, OAS will be available for third graders in every school in NYC during the 1997-1998 school year.

Objectives:

The anticipated goals of OAS are to reduce the number of episodes of severe asthma attacks among school aged children and increase their level of confidence towards the management of their condition which will ultimately improve their academic performance.

The outcome measures being used to evaluate the activity are: 1) pre- and post-test questionnaires to children who have completed the program, 2) pre- and post-test questionnaires to parents of children who have completed the program, 3) pre- and post-test questionnaires to nurses trained to implement the OAS curriculum, 4) assessment of knowledge, attitudes and practices of children who have managed their condition, 5) reassessment of absentee rates among children who have participated in the program, and, 6) reevaluation of health records among children who have participated in the program.

Role of Local Health Department:

Planning and Implementation: Bureau of School Health - participated on the OAS Task Force which served as the liaison between the ALA and public school nurses involved in OAS; provided implementation support and sustainment in schools; and, assisted with building and promoting community awareness of both asthma and the OAS initiative, and addressing asthma-specific issues.

BSH school health physicians, nurses, and public health assistants screened children attending public elementary schools; issued a parent survey to identify students in grades 3-5 with documented cases of asthma; and selectively enrolled these students into the OAS program. A maximum of 10 students were enrolled into the six-week program.

Evaluation: Evaluation will consist of analysis of pre- and post-test questionnaires from children who have completed the program and from their parents. Attendance and health records will be examined and in addition BSH will evaluate the impact training has made on school health staff's ability to identify children with asthma.

Barriers Encountered:	Strategies to Overcome:
The expected goal was to implement the OAS in each public school with a trained nurse. Approximately 108 public health nurses were trained to implement the curriculum. Staff attrition and lack of time were the two most common reasons given for school nurses not implementing the program. Lack of parent compliance and reluctance to sign children in the program. Difficulty in obtaining space, room and time to host the OAS classes. Lack of support from principals and teachers.	Encouraging instructors to review curriculum before each session. Involving a trained instructor present at first session for support and assistance. Conducting beginning sessions with parents to familiarize and actively involve them in the education process. Keeping school principals and staff officially informed periodically of the implementation status of the program.

Key Partners/ Collaborators:

The New York City Board of Education, the American Lung Association, and Glaxo Wellcome, a leading manufacturer of asthma medication.

Accomplishments:

Throughout the 1996-1997 school year, 85 schools within NYC have implemented the program. As a result, 938 school-aged children have learned how to cope with their condition and have graduated from the OAS program.

Lessons Learned:

Partnerships are essential when initiating broad citywide community-based programs. When educational programs include training opportunities for public health staff, it is possible to expand roles to include more practical tasks and their effectiveness in providing services is greatly enhanced. This program was a great example of using partners with focused expertise to support developing roles/tasks critical to assisting with a major public health condition and applying new skills with public health case management in an environment where children are most captive and available to regularly participate.

BEST COPY AVAILABLE

School Bus Express

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:*

Develop tools standardizing data collection, analysis, reporting
Maternal, fetal/infant, child death reviews.
Culturally appropriate health education materials/programs.
Newsletters, convening focus groups, advisory committees, networks.
Monitor MCO marketing practices.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.
Pediatric risk adjustment methods & payment mechanisms.
Comparative analysis of HC delivery systems.

MCH Initiatives:

Immunization.
Reducing transportation barriers.
Reshaping urban MCH.
Expanded child health services.
School & health connections.
Building coalitions & partnerships.
School-linked/based services.
One-stop shopping locations.
Immunization tracking/recall.

Funding Sources:

Budget: $1,000

City/County/Local government funds.
Other Federal funds.

Description:

The City of Newark is unique in that birth certificates are not automatically sent to mothers of new infants, and there is a one through two week(s) processing delay.

The Department of Vital Statistics located at City Hall is where one must go to order a birth certificate. Many families do not do this until the child is ready to register in daycare, pre-school, or kindergarten. These children also are delinquent frequently in immunizations.

School Bus Express places a health care team in conjunction with the Department of Vital Statistic and extends the normal working hours to include evening and Saturday session just prior to the start of the school year. Families can get a birth certificate without the normal waiting period, have their vaccine status reviewed, and receive immunizations needed to comply with entry requirements.

This is the third year of the program and it has been increasingly successful.

Objectives:

This program will expedite school entrance. New school registrants will be ready to enter the first day of classes, which is important because only a limited number of absentee days are allowed per school year.

Success of the program is determined by the number of birth certificates given and the number of immunization records reviewed/updated.

Role of Local Health Department:

This is entirely a health department activity. It was conceived by the department, and all aspects of its implementation and evaluation are internal.

Future improvements include new computer software to speed up processing, consideration of added sites for vital statistics via computer terminals, and improved staff education.

Barriers Encountered:	Strategies to Overcome:
Poor community compliance with preparedness/for school entry	Education, advertisement, interagency cooperation
Poor understanding of preventive health care through early immunization	Education, advocacy, advertisement
Hours of operation	Increased hours and staffing

Key Partners/ Collaborators:

Newark Public School System, Newark Pre-School Council, Child Care Centers, Other Newark City agencies

Accomplishments:

This program has decreased the waiting time to receive a birth certificate (normally 7 - 10 days processing time) and has promoted cooperation between the school district, daycare organizations, pre-school programs, and the local health department. There is expanded access to immunizations and city services, increased awareness of school entry requirements, and emphasis on the importance of school attendance.

Lessons Learned:

The importance of not assuming that the public understands the need for documentation as an entrance requirement.

The success of one-stop-shopping and increased access is only as good as a general education program and advertisements outlining both the need and opportunities available for compliance.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17

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Child Car Safety Seat Program

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Culturally appropriate health education materials/programs. Development of models. Provide infrastructure/capacity for MCH functions. Labor capacity. Provide outreach services. Identify high-risk/hard-to-reach populations.	Expanded child health services. Injury (including child abuse). Children with special needs. Reducing transportation barriers. School & health connections. Other outreach activities. Staff training.

Funding Sources:

Budget: Not reported.

Other: Car Restraint Special Device Fund to fund program state-wide.

Description:

The Norfolk Department of Public Health began in October of 1996 to implement the Virginia Department of Health Car Safety Seat (CSS) Program locally. Free safety seats for children from birth up to 4 years of age (with emphasis on those under 12 months) are provided to Medicaid eligible families. Seats are also provided to Medicaid eligible pregnant women in the last trimester of pregnancy.

The applicant must prove eligibility and attend a class which consists of a lecture, video tapes, showing safe installation in a variety of car seat belt arrangements; demonstration of installation in the car brought to class by the applicant and then a return demonstration by the applicant. If the parent has no car then the instructor's car is used. The whole process lasts approximately 3 hours. Literature is provided to the participants with drawings of correct installation for their later reference. Additionally, the instructors have been able to provide the safety seat classes and checks for those citizens who already have child safety seats and want to be sure they are installing them correctly. A Virginia study suggests 90% of seats in the state are improperly installed.

Objectives:

The expected results of this program are that the most needy families in Norfolk will receive car safety seats for their children and they will use them correctly and consistently.

Role of Local Health Department:

Our main responsibility has been implementation. The public health nurse has visited a variety of settings with in services, posters and referral information to reach out to the community. These included hospital maternity clinics, homeless shelters, two Resource Mothers' Program, Infant Programs, WIC, Division of Social Services, private pediatricians and obstetricians, and many other programs that deal with young children and pregnant women.

Barriers Encountered:	**Strategies to Overcome:**
Training of staff. Adequate space to store car seats.	Enlisted help of other disciplines -- have trained 2 environmental health persons. Forming partnerships with other agencies such as local fire departments and the Department of Division of Motor Vehicle. Worked with managers of several multi-service centers to identify locked spaces for storage.

Key Partners/ Collaborators:

Virginia State Health Department, Department of Motor Vehicles, and Norfolk Fire Departments.

Accomplishments:

Since January, 206 safety seats have been given out and 194 (100%) of the parents/guardians have attended the classes and have been able to demonstrate correct installation of the car seats. The "no show" rate for scheduled classes has been only 14%.

The public health nurses at Coronado Alternative School for Pregnant Adolescents arranged for the class to be presented to 38 students who attended there, with seats distributed to 13 students.

Lessons Learned:

There is a great need for this type of program and parents have expressed, they have learned there is more to safely installing a seat than just hooking a seat belt through. The use of appointment cards and reminder calls really does work to help keep "no show" rates down. Make arrangements for a covered area for demonstration of seat installation during inclement weather or obtain demonstration car seats with seat belts installed which can be used inside.

Smart Start

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E-mail:

Replicated Elsewhere?
Yes. Seven other states, four other counties in Oklahoma.

Updated Profile?

Essential MCH Functions:*
Develop tools standardizing data collection, analysis, reporting
Analysis of demographics, economic status, behaviors, health status.
Population surveys (BRFS, PRAMS, PedNSS, YRBS).
Hotlines, print materials, media campaigns.
Culturally appropriate health education materials/programs.
Assessment of provider reports regarding process and outcomes.
Newsletters, convening focus groups, advisory committees, networks.
Promote compatible, integrated service system initiatives.
Provide infrastructure/capacity for MCH functions.

MCH Initiatives:*
Family Planning.
Prenatal care.
Early intervention/zero to three.
Violence prevention/at risk.
Family violence.
Overcoming cultural barriers.
Staff training.
Strategic planning.
Securing MCH assistance.

Funding Sources:

Budget: $263,000

City/County/Local government funds.
Private source(s): Presbyterian Foundation, Other
Federal funds.

Description:

Smart Start is a community-based program which offers home visitation services to first-time mothers and their families. Registered nurses, with special training, perform home visits from the time of enrollment (before 26th week of pregnancy) until the child's second birthday. Services provided include physical and emotional health promotion, education, and community referrals and assistance.

Objectives:

The outcomes expected for the program are healthier pregnancies for more first-time mothers, better delivery outcomes, decreases in injuries and abuse of children 0-2 years, and an increase in family planning utilization. Tools for outcome evaluation include a parenting inventory administered prenatally, in the postpartum periods and again at the end of the program, a Healthy Habits Maternal checklist and demographics collection.

Role of Local Health Department:

Our health department provided most of the referrals to the program from its Maternity and WIC clinics. In addition, the health department provided partial funding, training for the RNs, and most of the educational materials for the program.

Barriers Encountered:	Strategies to Overcome:
Guidelines for program had restrictive target areas.	Boundaries were expanded.
Language barriers.	Hired one Spanish speaking RN.

Key Partners/ Collaborators:

The Smart Start nurses have relied on CCHDOC for not only funding, training and materials, but most of the clients were provided through referrals from CCHDOC's Maternity and WIC clinics.

Accomplishments:

Initiating the program, implementing program goals and raising public awareness.

Lessons Learned:

The most important lesson learned from this program is that the need for home visitation services is great. Early intervention impacts the mother in her life course development as well as impacting the child.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

Protocols for Assessment of Substance Use in Perinatal Populations

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Promote compatible, integrated service system initiatives. Public advocacy for legislation & resources.	Prenatal care. Staff training.

Funding Sources:

Budget: $4,500

MCH block grant funds.

Description:

Community health nursing agencies reported to the DCHD a concern about the impact of perinatal substance abuse in our community. At a system level, there was no consistent policy or practice in or between hospitals. A special concern was repeat drug exposed births in the same family. In 1995, the DCHD contracted with Nebraska Methodist College nursing faculty to conduct a study of perinatal providers' policies and practices in assessing substance use. Through key informant surveys, faculty also identified barriers and recommendations to assure provider attention to this issue. In 1996 and 1997, a work group of perinatal providers developed a protocol document for the community. A similar project in North Carolina contributed to the Omaha document.

Objectives:

The project expects to assure consistent policies and provider practices in drug screening pregnant women. Through early case finding and intervention, birth outcomes will improve. Initial outcome measure will be adoption and implementation of protocol in area hospitals and health system perinatal clinics.

Role of Local Health Department:

DCHD staff developed and monitored the request for technical assistance; obtained seed grant funds for two years; served as communication link with community providers during the study and model development. MCH coordinator monitors additional funding opportunities to implement the project with provider training and support for a prevalence study.

Barriers Encountered:	**Strategies to Overcome:**
Lack of resources to conduct a prevalence study to document need. Provider perception of prevalence in practice "not in my practice." No community based prevention funds dedicated to perinatal provider training.	Plan to seek funds through local hospital research foundations. Initial implementation at hospital system as historically successful diffusion strategy. Monitor and seek available funding for provider training staff support.

Key Partners/ Collaborators:

Nebraska MCH program, Nebraska Methodist College of Nursing, volunteer attorney, Nebraska Genetic and Teratogen Project, regional substance abuse prevention center, representatives of community health nursing, hospital, OB department, private sector physician offices, local health department.

Accomplishments:

In 1995-96 the project completed a perinatal provider survey. By June 1997, developed a final draft "Protocol for Assessment of Substance Use in Perinatal Populations" that includes: assessment tools, legal and ethical issues, community substance abuse resources, clearinghouse information, and references.

Lessons Learned:

The Douglas County Health Department benefited from community health nursing expertise at the College.

Discussion of a health issue at the community level contributes to internal institution discussion about policy and practice. One work group participant reported that follow-up discussions with institution medical staff focused attention on inconsistent internal policies and practices in identification and intervention of perinatal substance use. For two years she had been unsuccessful in starting this discussion. The external community based initiative encouraged the internal assessment. Changing organizational practice is a prevention strategy.

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7th Grade Immunization Project

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:
- Laboratory capacity.
- Monitor enrollment practices for ease of use.
- Identify high-risk/hard-to-reach populations.

MCH Initiatives:
- Immunization.
- Building coalitions & partnerships.
- School-linked/based services.
- Reducing transportation barriers.
- School & health connections.

Funding Sources:

Budget: Supplies: $2,690

City/County/Local government funds.

Description:

During the spring of the 1996-97 school year, the Orange County Health Department, in collaboration with the Orange County Immunization Improvement Coalition, provided immunizations at 23 Orange County middle schools. This was done in preparation for new immunization requirements for students entering 7th grade in the 1997-98 school year. Nearly 4,000 6th grade students received immunizations on three separate days in order to complete the Hepatitis B series of three vaccines, a measles, mumps, rubella (MMR) booster, and a tetanus diphtheria (Td) booster.

Objectives:

The goal of this project was twofold: 1) to provide immunizations to 6th grade students with little or no health insurance coverage, and 2) to provide the opportunity for working families to obtain the required immunizations for their children without being absent from the workplace.

Role of Local Health Department:

The Orange County Health Department provided the vaccines, supplies, technical expertise and training required for this immunization project. Provision of information to the media, schools and community also resulted in the education of parents, students and other immunization providers regarding the new immunization requirements for 7th grade entry.

Barriers Encountered:
- 10,000 6th grade students in need of immunizations.
- Lack of awareness by parents of the new school requirements for 7th grade entry.
- Rural areas with limited health care access.
- Limited health department personnel.

Strategies to Overcome:
- Extensive publicity regarding the new 7th grade entry immunization requirements was accomplished by the Orange County Health Department, Orange County Public Schools and local print, TV and radio media.
- Providing immunizations at the middle school sites allowed working parents and those with limited health care access to obtain free immunizations for their children without having to leave their workplace.
- Medical and clerical volunteers from multiple public and private community agencies received training from the Orange County Health Department staff to provide immunizations and assist with documentation.

Key Partners/ Collaborators:

Agencies participating in the school immunization project included: Orange County Immunization Improvement Coalition, Orange County Public Schools, Orange County Fire Rescue Division, Hope for Kids, Kiwanis, Rotary, Disney Group Insurance, Humana Health care, nursing students and instructors from Seminole Community College, Valencia Community College and the University of Central Florida, as well as numerous medical and clerical volunteers from public and private agencies and businesses resulting in over 500 volunteer personnel.

Accomplishments:

Nearly 4,000 6th grade students at 23 middle schools received 14,689 necessary immunizations (valued at $123,087) for 7th grade entry on three separate days over a four month period. On the first day of the 1997-98 school year, approximately 80% of the 10,000 6th grade students had received the required immunizations for school entry. Of the 8,000 students who had documentation of the required vaccines, 50% had received their vaccines through the school immunization project.

Lessons Learned:

1) Expect procrastination in compliance with new mandates and provide multiple opportunities for accessing services. 2) In addition to early education and service provision efforts, also plan for several mass efforts immediately preceding the implementation of the new regulations. 3) Collaboration from both the public and private sector are vital for disseminating information and implementing universal health mandates.

Central Florida Drowning Prevention Task Force

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Develop tools standardizing data collection, analysis, reporting Community perceptions or health problems/needs. Maternal, fetal/infant, child death reviews. Culturally appropriate health education materials/programs. Prepare, publish, and distribute reports. Develop & promote MCH agenda & YR2000 National Objectives.	Injury (including child abuse). Other outreach activities. Strategic planning. Building coalitions & partnerships. Infant/child death review.

Funding Sources:

Budget: Not reported.

Not reported

Description:

The Central Florida Drowning Prevention Task Force was established to address the goal of reducing preventable drownings and near-drowning in the multi-county catchment area. This initiative was built on partnerships between public, private and community-based organizations. The first meeting took place on June 6, 1997. Participation includes representatives from many key stakeholder groups including: the medical community, the written and electronic media, county Emergency Medical Services, city and county government.

State statistics indicate that Florida has the third highest drowning rate in the country with Orange County recording the highest drowning rate of any in-land area in the State of Florida. From 1996 to June 1998, there have been 35 drownings in the Central Florida area.

Objectives:

1) To significantly decrease the drowning and near-drowning rate among preschoolers. 2) To organize an effective work group to develop educational projects designed to increase public awareness. 3) To conduct on-going research, development and collection of statistics. 4) To develop policy regarding data collection, case definition and reporting to the Orange County Health Department Epidemiology Division. 5) Initiate legislative action to require intermediate physical barriers proximal to private pools.

Role of Local Health Department:

The Health Department conceived, developed and facilitated this multi-county initiative. The effort is supported through administrative guidance and encouragement of all activities as well as provision of "grassroots" participation. Staff from the Health Education division coordinates and oversees the task force.

Barriers Encountered:	Strategies to Overcome:
1) The challenge was to get everyone at the table and on the same page. We quickly discovered that there were many methods of data collection, reporting, and evaluation of drowning incidents among agencies; many within the same county. This has made the gathering of reliable statistics very difficult. Also, drownings and near-drownings are not mandated for reporting by the State of Florida.	1) The task force has organized a research and data collection committee to address the problem of inconsistent data collection. We are requesting voluntary reporting of incidents related to drowning and near-drowning.
2) There is no universal definition of "drowning" or "near-drowning."	2) We have collected the most widely accepted definitions and criteria for "drowning" and "near-drowning" and the task force will review these and make a determination regarding which parameters to use when referring to drowning and near-drowning.
3) Limited funding sources.	3) Seek funds from the private sector and from grants to expand community awareness.

Key Partners/ Collaborators:

The Central Florida Drowning Task Force has community representation from the following stakeholders: city and county government, county Emergency Medical Services, health departments, written and electronic media, private industry, non-profit organizations, consumers and hospitals.

Accomplishments:

The Orange County Drowning Prevention Task Force, originally to be made up of representatives from one county, quickly grew and now includes more than ten counties in the Central Florida area. The support and commitment from the task force has been overwhelming. Representatives of the task force come from a wide array of groups and organizations, business, government and the public and private sector.

Lessons Learned:

The ability to bring together representatives from a multitude of disciplines and interests in an effort to address the tragedy of preventable drownings. Time and attention is needed to provide ongoing support and nurturing of the task force. It is crucial to establish goals and objectives at the beginning of the collaboration and to monitor the groups progress and direction.

It is imperative that all involved be consistent with the case definition of "drowning" and "near-drowning."

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Project Success: School Health Liaison

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:*

Analysis of demographics, economic status, behaviors, health status.
Hotlines, print materials, media campaigns.
Prepare, publish, and distribute reports.
Special studies.
Newsletters, convening focus groups, advisory committees, networks.
Provide outreach services.
Transportation & other access-enabling services.
Monitor enrollment practices for ease of use.
Profiles of provider attitudes, knowledge & practices.

MCH Initiatives:*

Immunization.
School-linked/based services.
Dental programs.
Reducing transportation barriers.
One-stop shopping locations.
Mobile clinics for outreach.
Increasing access to Medicaid.
Reshaping urban MCH
Building coalitions & partnerships.

Funding Sources:

Budget: $200,000

City/County/Local government funds.
General state funds.
Private source(s): Local business; private health care providers,
Third party reimbursement (Medicaid, insurance)

Description:

Project Success is an initiative of the Illinois Governor's office which provided start up funding to communities to build and coordinate a network of community leaders, parents, teachers, and human service providers so that all children and families receive the services they need to be successful in the classroom. The importance of six core components are to be assessed and prioritized by the community within a Community Action Plan. The six core components are to ensure access to: basic preventative health care for children and family; proper nutrition and nutrition education; prevention and rehabilitative mental health services for child and family; services that will protect children and promote the stability of the family; substance abuse prevention, intervention and treatment of children and their families; and social activities which enhance positive interaction within families.

An initial concern of Peoria's Project Success Network was the high exclusion rates of children from school due to lack of compliance with Illinois Codes requiring immunization, medical, and dental exam at grades K, 5, and 9. Six schools were targeted. A health fare consisting of volunteer providers, supported by local businesses and organizations with outreach being done by parents and school personnel provided an opportunity for children to access these required services. Over four years Project Success continues to expand and currently serves 18 schools. Two years ago the Peoria City/County Health Department provided a half-time Public Health Nurse to the Project to provide consistent assessment of health needs and coordinate health resources for the network.

Objectives:

1) Decrease the numbers of children excluded from schools. 2) Improve health status of school age population. 3) Improve access to primary health care services for both children and their families.

Role of Local Health Department:

The Peoria City/County Health Department assisted in the initial proposal development, served on the Local Governing Board, provided immunizations and dental exams. As expansion was considered, the Peoria City/County Health Department funded a PHN position to identify health needs and coordinate resources of Project Success members to address, replicate, and expand and evaluate the process in all Project Success schools.

Barriers Encountered:	**Strategies to Overcome:**
Mobilizing and coordinating multiple resources. Hanging in long enough to see payback.	Key players accepting more responsibility to use their networks to increase the network. Principals/parents sharing their successes with each other.

Key Partners/ Collaborators:

Peoria Public School District 150: staff and families, the Children's Home, Methodist Medical Centers, Illinois Department of Public Aid (local office), Illinois Department of Children and Family Services (local office).

Accomplishments:

Children excluded from attendance at Peoria Public Schools as of October 15, 1993 were 1,122. Children excluded as of October 15, 1996 were 515. Four Project Success schools had zero exclusion rates. Mental Health screening and an established community based intervention system for low income families was added to the exam process of health fairs. Schools report increasing parental involvement and ownership in the success of their children and in the making of health care decisions for their families.

Lessons Learned:

Coordinated community response based on common vision, goals, and objectives with partners who are able and willing to commit resources to secure the vision is a key component to the success of a collaborative partnership.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

BEST COPY AVAILABLE

Female Condom Initiative

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:
Maternal, fetal/infant, child death reviews.
Hotlines, print materials, media campaigns.
Culturally appropriate health education materials/programs.
Special studies.
Provide infrastructure/capacity for MCH functions.
Laboratory capacity.
Monitor enrollment practices for ease of use.

MCH Initiatives:
Family Planning.
Teen pregnancy.
Communicable diseases.
Overcoming cultural barriers.
Expanding private sector links.
Other outreach activities.
Building coalitions & partnerships.

Funding Sources:

Budget: $200,000

City/County/Local government funds.

Description:

In 1993, the female condom was approved by the U.S. Food and Drug Administration as an effective method of disease prevention and pregnancy prevention. As recently as the summer of 1995, however, many Philadelphia providers and policymakers continued to express highly negative attitudes toward this method of prevention. These biases seriously reduced patients' knowledge of and access to the female condom. Anecdotal evidence suggested that many women are unable to convince their sexual partners to use a male condom, thus exposing themselves to infection and unintended pregnancy. Unacceptably high rates of sexually transmitted diseases supported the assumption that a high level of unprotected sexual activity was occurring in Philadelphia. The Philadelphia Department of Public Health recognized the need to promote a new, effective method of protection that could be controlled by women. In July 1995, the Health Department launched a public education campaign to increase awareness, acceptance and use of the female condom by both patients and their providers throughout Philadelphia. The Health Department has collaborated with a broad range of traditional and non-traditional health educators to promote the availability of female condoms and related educational presentations

Objectives:

The response to this initiative has been overwhelming. Requests have poured in from sources as varied as health clinics, church groups, college sororities, nonprofit organizations, sex workers, AIDS agencies, social workers, couples and individuals. Sample condoms and bilingual counseling kits (including a poster, a motivational videotape, promotional buttons) have been distributed in all of Philadelphia's diverse neighborhoods. Due to an overwhelming demand, an initial order of 80,000 female condoms was exhausted between July and November 1995. A second order for 165,000 female condoms arrived in December 1995; subsequent orders of equal number have kept the initiative running since then. In addition, the initiative's coordinator negotiated with the female condom manufacturer so that Health Department contract organizations could purchase their own female condoms at a similarly discounted rate.

Role of Local Health Department:

The Philadelphia Department of Public Health has taken the lead in promoting this initiative. Philadelphia was the first U.S. city to throw the weight of its public health department behind an extensive public awareness campaign about the female condoms. The initiative has thrived as a direct result of unprecedented cooperation among several Health Department divisions: Office of Maternal and Child Health, AIDS Activities Coordinating Office, Office of Ambulatory Health Services, Coordinating Office for

Drug and Alcohol Programs, and the Division of Disease Control. In an effort to shift costs from the Health Department, the initiative has aggressively promoted the availability of female condoms through medical assistance with prescription coverage.

Barriers Encountered:	**Strategies to Overcome:**
Provider resistance.	Ongoing provider education and training.
The high cost of the female condom.	Discounted rate from the manufacturer; pooled resources from various Health Department divisions.

Key Partners/ Collaborators:

Key partners/collaborators include any organization or individual that serves as a community leader/peer educator: health clinics, church groups, college sororities, nonprofit organizations, block captains, sex workers, AIDS agencies, social workers. Both traditional and non-traditional partnerships were developed for this initiative to reach the broadest number of communities.

Accomplishments:

The coordinator of the campaign has appeared regularly on radio and television to promote the female condom. Articles and editorials have appeared in Philadelphia's two major daily newspapers (the Inquirer and Daily News), as well as in several community-based newspapers. The coordinator has conducted more than 100 educational presentations to groups ranging from 10 to 200 people. A variety of brightly colored and literacy appropriate flyers were developed to promote the initiative in clinics and community-based organizations. Female condoms have now been fully integrated into the family planning services of Philadelphia's eight Health Care Centers. Most outreach organizations funded by the Health Department now distribute female condoms in quantities comparable to male condoms. The Health Department has provided a public service and generated good will by offering its discount rate to subcontract organizations and other interested agencies. The initiative has broadened choices available to women. It has also demonstrated that professional education can be successful in breaking down misperceptions about new and sometimes intimidating technologies.

Lessons Learned:

With appropriate education and counseling, the female condom is a method of protection that is easy for women to learn to use. Many women like it, use it, and tell other women about it. Many men like it, too. When materials are made available, people from all corners of the community will spread the word about this new method of protection. Health care providers can overcome their resistance to the female condom through targeted professional education.

County Block Grant

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Replicated Elsewhere?

Yes. In other Arizona counties.

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Hotlines, print materials, media campaigns. Assessment of provider reports regarding process and outcomes. Newsletters, convening focus groups, advisory committees, networks. Laboratory capacity. Transportation & other access-enabling services. Monitor enrollment practices for ease of use. Identify high-risk/hard-to-reach populations. Profiles of provider attitudes, knowledge & practices.	Preconception promotion. Prenatal care. Teen pregnancy. Overcoming cultural barriers. Other outreach activities. Case coordination. Strategic planning. Building coalitions & partnerships.

Funding Sources:

Budget: $368,000

City/County/Local government funds.
General state funds.

Description:

The County Prenatal Block Grant was created by the Arizona State Legislature in 1996 for FY 1997. The funds are passed through the Arizona Department of Health Services and have replaced the allocation previously used for the Teen Prenatal Express Program. It was designed to assist teens access to prenatal care; improve birth outcomes; and decrease the incidence of subsequent teen pregnancies. The funding formula for the Block Grant included three components: 25% allocated according to population, 25% allocated according to need, and 50% allocated according to amount received in prior years.

Three factors were used to assess the need of a county and they included the rate of women receiving late or no prenatal care, the rate of newborns requiring intensive care services, and the rate of low birth weight infants. The grant focused on supporting community empowerment that would lead to the development of better systems to serve people; public funds would be used to create action by communities rather than for them. Our role as a local health department included developing a community plan based on needs, focusing on systems development and service delivery, and providing leadership to this process.

Objectives:

The expected outcome is to the improvement of the health of maternal and child health (MCH) target populations (women of child bearing years, pregnant women and infants), and the improvement of the human service system operations.

Role of Local Health Department:

The Maricopa Department of Public Health Services, as the lead agency will assume responsibility for the coordination and implementation of the plan. Collaboration will begin with agencies represented on the MCH Advisory Group and as defined by the Action Plan.

The Needs Assessment and the Plan of Action will be updated at least annually and the MCH Advisory Group will continue in the role that has been developed over the past 12 months.

Barriers Encountered:	Strategies to Overcome:
Overall statistical data for Maricopa County does not necessarily reflect findings in many pockets throughout the county where significant variances exist in health status indicator outcomes. In urban areas, population is spread out over many miles versus the densely populated areas that exist in many U.S. cities. Limited public transit systems exist. No public transportation available in many areas. Increase in the numbers of culturally diverse populations living within the county. Inadequate number of health care providers who are bilingual and sensitive to cultural differences impact health care and outcomes. Increase in the numbers of people moving into the county metropolitan area. Political environment of the State Legislature and resulting decisions. Focus on abstinence education by local, state and federal governments. Diminishing local funding support for public health programs. Welfare Reform. Changes in the local health care systems and reimbursement methods. Funding limitations.	The MCH Plan of Action is just in the beginning stages of implementation.

Key Partners/ Collaborators:

Members of the MCH Advisory Group have been the key collaborators in these activities. These members represent agencies such as: Arizona Health Care Cost Containment System (AHCCCS-the State managed care medical program), ComCare (Menatl Health), Teen Pregnancy Coalition, Tolleson Union High School District, Community Health Centers, Maricopa County Superior Court Systems, Maricopa County Inmate Services, Arizona State University, March of Dimes, Prenatal Care Coalition, Arizona Department of Economic Security, clients previously utilizing our services, and the Maricopa County Health System including the Hospital and Family Health Centers.

Accomplishments:

1) A MCH Advisory Group has been developed and met five time since the beginning of the project.
2) Community Input Process: A series of five community forums were held through-out the county.
3) Needs Assessment: The needs assessment document was developed and the first printing was completed and distributed by April 8, 1998.
4) Interim Client Services: The goal was to have a continuum of services that was need-driven, versus one driven solely by funding. Three major service areas were identified for the Office of Family Health -- Preconception and Well Woman Services, Pregnancy Services, and Parenting/Family Care Services.
5) MCH Plan of Action: The needs assessment was the foundation for development of an MCH Action Plan.

Lessons Learned:

Never attempt to do a needs assessment without the assistance of a consultant in a county as large and diverse as Maricopa. It contains 58% of the population of the State of Arizona and includes Phoenix, which is the 6th largest metropolitan city in the U.S.

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Resource Mothers Project

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E-mail:

Replicated Elsewhere?
No

Updated Profile?
Yes 1995

Essential MCH Functions:	**MCH Initiatives**:
Implement public MCH program client data systems. Analysis of demographics, economic status, behaviors, health status. Hotlines, print materials, media campaigns. Special studies. Newsletters, convening focus groups, advisory committees, networks. Promote compatible, integrated service system initiatives. Laboratory capacity. Provide outreach services. Transportation & other access-enabling services.	Home visiting. Low birthweight/infant mortality. Breastfeeding/nutrition/WIC. EPSDT/screenings. Teen parenting. Overcoming cultural barriers. Reducing transportation barriers. Increasing social support. Case coordination.

Funding Sources:

Budget: $400,000

MCH block grant funds.

Description:

The Resource Mothers Project is an intensive outreach initiative to pregnant women and teenagers and their infants in three high-risk communities. Initiated in 1993, the Project is designed to reduce infant mortality, promote early enrollment in prenatal care and improve the utilization of available health and social services.

Staff consists of lay home visitors (Resource Mothers), social workers, and a nurse. The Resource Mothers (RM) are all mothers with low-income backgrounds who have themselves been WIC participants, MA recipients, etc. The professional staff and RMs work as a team with the RM having the primary relationship with each family. The RMs visit each family at least monthly from enrollment until the infant is one year of age. They assist women in obtaining health care for themselves and their infants and to carry out the recommendations of the health care providers, facilitate entry into MA, WIC, etc. They promote parent-infant bonding and infant development and support school attendance, job training, etc.

Objectives:

The expected outcomes include earlier enrollment in prenatal care within the target communities, decreased low birth weight and infant mortality rates, optimal utilization of preventive health care, including immunizations, delayed subsequent pregnancies and enrollment in school or vocational training programs.

Role of Local Health Department:

The Resource Mothers Project was planned, implemented and evaluated by Allegheny County Health Department. It receives fiscal support through the Pennsylvania Department of Health. Replication materials from the National Commission to Prevent Infant Mortality are utilized.

Barriers Encountered:	Strategies to Overcome:
Utilizing a multidisciplinary team in service provision.	Training on team building, supporting all staff members, clarifying all members' roles.
Contracting issues.	Working to streamline procedures.
Inability to hire mothers who have been on WIC, Medicaid, etc.	Contracting with a private, nonprofit agency.
Transportation for RMs and clients.	Providing bus tickets and leasing a van.

Key Partners/ Collaborators:

A very important partner was the agency through which the RMs were initially recruited and trained. We are currently exploring the feasibility of moving this Project to private, nonprofit management in order to improve the coordination of similar home visiting services and enable the Department to assume an expanded role in assurance and assessment.

Accomplishments:

1) Reaching high risk women. 2) Improved utilization of prenatal care (first trimester care increased 3.4% in the County as a whole, but 12.3% in target areas). 3) Reducing the infant mortality rate (by 6.2/1000 live births within 1-1/2 years of implementation). 4) Reducing low birthweight (declined 16.7% in target areas, no reduction in the County). 5) 88% of participants delayed subsequent pregnancies. 6) 66% stayed in school or vocational training programs; others planned to return when infant was older.

Lessons Learned:

A team approach can be a highly effective intervention method for high risk pregnant women and mothers. It combines the abilities of lay home visitors to mentor and communicate with clients, with the knowledge and skills of professional staff. We estimate a cost of $1,876/family and a savings in excess of $2,500/family, not including intangible benefits such as improved quality of life.

WIC/Lead Screening Demonstration Project

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Replicated Elsewhere?
Yes Other cities and towns in Maine

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Special studies. Community perceptions or health problems/needs. Monitor enrollment practices for ease of use. Pediatric risk adjustment methods & payment mechanisms.	Lead poisoning. Breastfeeding/nutrition/WIC.

Funding Sources:

Budget: $5,000

City/County/Local government funds.
MCH block grant funds.
Other Federal funds.

Description:

Prior to the time of the demonstration project, September 1996, no screening for lead poisoning was being conducted at WIC clinics either by questionnaire or direct capillary testing anywhere in Maine. Our project was time limited and aimed at determining feasibility, practicality and effectiveness of offering lead screening services on-site at WIC clinics in the Portland area. The expectation was that the model could be replicated statewide if successful.

Objectives:

1) Lead screening and education to be integrated into WIC screening activities.
2) Previously undiagnosed children will be identified with lead poisoning.
3) WIC families will gain greater awareness of lead poisoning hazards, and the relationship nutrition plays in preventing and treating lead poisoning.

Role of Local Health Department:

The Portland Public Health Division initiated the proposed partnership with WIC with the intent of initially staffing the WIC clinic and gradually transitioning out so that WIC staff ultimately assumed responsibility for incorporating lead screening into the clinic routine.

Barriers Encountered:	**Strategies to Overcome:**
Cost of capillary lead testing lab fee - $15. Additional demand on WIC staff time. Need for WIC staff training on lead poisoning.	Fee waived for uninsured populations. Need for additional funding to support initiative - increase manpower. State to act as technical consultant for implementation and training needs.

Key Partners/ Collaborators:

Portland WIC office.
State Bureau of Health including state WIC director and state lead poisoning prevention director.

Accomplishments:

18% of children screened were identified with levels (greater than 9 ug/dl) verifying need for continued screening. The State Bureau of Health is now preparing a plan for implementation of lead screening at WIC sites in other communities statewide where lead hazards are significant.

Lessons Learned:

The mission and objectives of the WIC program are completely compatible with the concept of integrating lead screening and educational activities and coincides with the CDCP's recommendation for targeted screening. Previously undiagnosed children were identified during the project period. Our local WIC office embraced this joint project as an opportunity to better serve the community, but also felt strained from the burden of so many other unfunded and less compatible mandates imposed at the federal level.

Child Opportunity Zones, "Starting Points"

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:
Special studies.
Newsletters, convening focus groups, advisory committees, networks.
Laboratory capacity.

MCH Initiatives:
School-linked/based services.
School & health connections.
Building coalitions & partnerships.
Strategic planning.
Other outreach activities.
Overcoming cultural barriers.
One-stop shopping locations.
Case coordination.

Funding Sources:

Budget: $50,000

MCH block grant funds.
Private source(s).
Other Federal funds.

Description:

Birth to age 6/Family centers providing health/education supports to meet community needs. Year three of joint DOH/DOE/Carnegie/United Way collaboration. COZ sites in Providence at D'Abate and Gilbert Stuart Elementary schools offer parent training; TA and linkage with services across health, substance abuse, education, mental health and human services systems.

Objectives:

Children entering school ready to learn. Reading level at grade 4.

Role of Local Health Department:

To provide leadership in pursuing integrated services delivery model; assist strategic planning effort at community level; and offer needs assessment resources.

Barriers Encountered:
Turnover in staff.
Difficulties in developing government and management plans/roles.
Unstable funding.

Strategies to Overcome:
Enhanced visibility of initiative.
More investment in staff/development/parent training.
State support for strategic planning process.

Key Partners/ Collaborators:

Director of Health - Patricia Nolan, MD
Medical Director - Division of Family Health - Bill Hollinshead, MD
Director of MCH Policy - Laurie Petrone

Community Coordinator - Mia Patriarca

Accomplishments:

Community assessments complete; action plans developed; third year of funding supporting a range of parent education, and training activities; and resources to assist families leveraged from local CBOs, RI DOH, and Rhode Island Department of Education.

Lessons Learned:

State accountability requirements create tension; communities need to be given the power to make decisions about how local investments are made and evaluated.

Child Health Outreach Project

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:
Laboratory capacity.
Provide outreach services.
Transportation & other access-enabling services.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.
Develop & promote MCH agenda & YR2000 National Objectives.
Newsletters, convening focus groups, advisory committees, networks.
Maternal, fetal/infant, child death reviews.
Hotlines, print materials, media campaigns.

MCH Initiatives:
Immunization.
Early intervention/zero to three.
EPSDT/screenings.
Expanded child health services.
Substance abuse prevention.
Dental programs.

Funding Sources:

Budget: $70,000

Other: North Carolina Smart Start

Description:

The North Carolina Smart Start initiative states that every child should be socially and developmentally ready to enter school. Funding is available to provide services to preschool children.

The Maternal Outreach Project currently serves infants with medical and social needs through the infant's first birthday. Many children and families "aging out" of the project continue to need the services of an outreach worker.

The Chow Health Outreach Worker (CHOW) project extends services to the infant's third birthday. The CHOW, as a member of the Baby Love team offers outreach, advocacy and support services to children and their families. They work one-on-one with children identified by the Child Service Coordination program with medical and social needs/delays. They become involved during the prenatal period and end services at child's third birthday. The projects are located in targeted communities in Wake County.

Objectives:

1. Increase number of children receiving social, developmental and behavior screening aged 0-3.
2. Increase number of well child and immunization rates of children served.
3. Reduce child abuse and neglect.
4. Increase knowledge of community, social and health resources in the community.
5. Increase involvement of businesses, community leaders and civic groups to address the needs of children.

Role of Local Health Department:

Lead role as initiative involves planning, gathering needs data, involving community partners, enrollment of families in project, coordination with other Smart Start initiatives.

Barriers Encountered:	Strategies to Overcome:
Outreach to under served populations. Language of consumers	Outreach staff are stationed in community. Smart Start Advisory Committees provide guidance for outreach. Bi-lingual staff.

Key Partners/ Collaborators:

Maternity Care Coordination Program, Child Service Coordination, Health Check Coordination Program, Day Care Centers, Work First Program, Local Businesses, religious and civic organizations, Headstart, Local Pediatrician offices and Child Health Clinics, SafeChild, East Wake Education Foundation, Fuquay-Varina Education Foundation, Ready to Learn Centers

Accomplishments:

1. Development of Smart Start Advisory Committee comprised of school staff, community partners and outreach staff to address needs of preschool population.

2. Training of staff in Parents as Teachers -- national program with positive results in preschool and parental development.

3. Case management of additional families.

4. Partnership with churches and daycare centers to provide workshop for parents and daycare providers.

Lessons Learned:

Not reported.

Richmond Healthy Start Initiative

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Replicated Elsewhere?
No

Updated Profile?
Yes. 1995

Essential MCH Functions:*

Develop tools standardizing data collection, analysis, reporting
Environmental assessments.
Hotlines, print materials, media campaigns.
Special studies.
Develop & promote MCH agenda & YR2000 National Objectives.
Ombudsman services.
Provide infrastructure/capacity for MCH functions.
Provide outreach services.
Profiles of provider attitudes, knowledge & practices.

MCH Initiatives:*

Preconception promotion.
Prenatal care.
Immunization.
Teen pregnancy.
Reducing transportation barriers.
Other outreach activities.
Case coordination.
Building coalitions & partnerships.
Infant/child death review.

Funding Sources:

Budget: $1,300,000

City/County/Local government funds.
Other Federal funds.

Description:

In 1994, Richmond City Public Department of Public Health was one of seven (7) cities awarded a $1,000,000/year grant as a Healthy Start Special Project. The seven Special Projects joined 15 original sites that had been in operation for two years to reduce the infant mortality rate and the number of low birth weight births in their respective locations. The National Healthy Start is a Division of the Maternal and Child Health Bureau of the Health Resources and Services Administration. Richmond Healthy Start Initiative has 12 contractors providing "wrap-around" services to support maternal and child health care. Services include: case management, transportation and child care to support compliance with medical appointments, parenting skill training, teen pregnancy prevention education, mentoring for teen mothers/pregnant teens, and on-site school infant day care.

Objectives:

Reduce Infant Mortality Rate in Richmond, Virginia, to 12.0 (compared to 15.2) by Year 2000. Improve birth outcomes--lower the number of low birth weight births. Reduce the number of pregnancies among teens by 15% of the current rate by the Year 2000. Reduce the number of unintended pregnancies among women age 18 and older by 30% of the current rate by the Year 2000.

Role of Local Health Department:

Richmond Public Health is the administrator for this program. RCDPH collaborates with community public/private agencies in providing maternal and child health support services.

Barriers Encountered:	Strategies to Overcome:
Women not seeing the importance of early, regular prenatal care. Teen parents with infants have multiple needs; it is difficult to address all of them. Lack of transportation for pregnant women and women with children, to get to medical appointments or purchasing prescriptive medicine. Difficult for client to negotiate the managed care organization system.	Providing public education--not just women but all family members and community members. Department of Public Health working with school system to establish school-based clinic. Seeking private funding to sustain program's work. Restructuring the Public Health Department to increase services, reduce duplication of services, and enhance networking and referrals through the Consortium.

Key Partners/ Collaborators:

Richmond City Department of Public Health is collaborating with Virginia Commonwealth University, The Virginia League for Planned Parenthood, the Virginia State Maternal and Child Health Department, Richmond Department of Social Services, Richmond Public Schools and 12 contractors (public/private agencies/providers, churches, etc.)

Accomplishments:

Of the mothers/pregnant women served, there have been no infant deaths and there are fewer low birth weight births. Richmond's IMR is dropping from 15.8 (1993) to 15.2 (1995). Provided *Postponing Sexual Involvement* training to approximately 1,200 adolescents (1996) in all public middle schools. Development of a 120+ member Healthy Start Consortium to foster service integration, networking, and collaboration.

Lessons Learned:

1. Research and implement only "best practices" from other successful evaluated programs.
2. Do not assume barriers--ask consumers what they are.
3. Define and develop what case management should "look like" across the board with all participating agencies, so that data reporting is unified.
4. Bring the consumers to the table early on and through out the program so voices and needs are heard.
5. Community liaisons are extremely valuable in outreach and recruitment; there are the entree to the communities--the trust and acceptance factors are there.
6. Data reporting system needs to be well established and in place at the onset of the program to support, assess and provide objective evaluations of programs.

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

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Monroe County Health Department's Child and Family Health Grant

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	MCH Initiatives:
Develop tools standardizing data collection, analysis, reporting Implement public MCH program client data systems. Special studies. Newsletters, convening focus groups, advisory committees, networks. Ombudsman services. Monitor enrollment practices for ease of use. Identify high-risk/hard-to-reach populations.	Home visiting. Case coordination. Building coalitions & partnerships. Building MCH data capacity.

Funding Sources:

Budget: Not reported.

MCH block grant funds.

Description:

This profile describes the development and implementation to date of the Child and Family Health Grant which is a partnership between the New York State Department of Health (NYSDOH) and Monroe County Health Department (MCHD) to create a decategorized, integrated service grant providing services to mothers and children for a total of 3.5 million dollars. The goal is to reorganize funding streams to create a flexible, seamless funding pool for key maternal-child health services to reduce costs and fragmentation and duplication of services. In January 1997, MCHD was successful in consolidating seven categorical grants from the NYSDOH into a blended maternal and child health services fund. These funds include: WIC, Lead Poisoning, Lead Interim Safe Housing, Community Health Worker, Infant Review, Immunization and Early Intervention/Infant Child Health Assessment Program.

Objectives:

The integrated approach will result in: a) a central data registry system which will include the previous seven categorical programs; b) a single point of entry for all maternal and child health services; c) a common intake form for all services; and, d) co-training of staff providing maternal and child health services.

Role of Local Health Department:

Monroe County Health Department took a lead role in articulating the concerns, issues that were occurring in attempting to provide integrated services to families under seven different categorized funding sources with varying reporting requirements and seven categorical databases.

Barriers Encountered:	Strategies to Overcome:
Changing the "system," changing the way of doing business, turf issues. Staff investment involvement over a period of time.	Patience, open communication, negotiations. Successful collaboration takes time. Involve staff at all levels. Rotate workgroup representation, set realistic goals to achieve some of progress along the way.

Key Partners/ Collaborators:

1) New York State Department of Health; 2) Meridian Consulting, Inc. - a small consulting group in Albany, NY who has assisted in the development of the workplan, facilitates regular workgroup meetings with the Monroe County staff and linkages with NYSDOH; 3) Women's and Children's Health Care Research Center at SUNY Syracuse taking the lead with Monroe County Information Systems to assist in the development of the central data registry system through a Data Utilization and Enhancement grant; and, 4) Monroe County Health Department staff providing Maternal-Child Health Services.

Accomplishments:

Successful negotiations resulted in one contract as of January 1997 for what was seven categorical contracts, budgets, and reports. One integrated work plan for all services with identified health status indicators and outcome measures. Report completed and submitted to NYSDOH quarterly.

Completed development and pilot of the proposed common intake form and screening tool.

Co-training occurred in October 1996 for maternal and child health services staff.

Lessons Learned:

This is an ongoing process. Develop ongoing, collaborative partnerships. Have patience. Involve and empower staff at all levels from frontline to administrative. Keep everyone informed and updated at regular intervals.

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Daycare Consultation

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Maternal, fetal/infant, child death reviews. Hotlines, print materials, media campaigns. Support of continuing education.	Communicable diseases. Overcoming cultural barriers. Reducing transportation barriers. Expanding private sector links. Staff training.

Funding Sources:

Budget: $7,650

City/County/Local government funds.

Description:

Teaching good hand washing to young children can be a challenging job. However, as public health professionals, we know that this is the basis for good infection control. With a small amount of funding, much hard work and the creativity of many dedicated professionals, the challenging job of teaching hand washing became easier and much more fun. Saint Paul - Ramsey County Department of Public Health facilitated a collaborative effort to develop new materials on why, how, and when to wash hands. The goal was to use materials that were scientifically based, reflect the cultural diversity of the community, were affordable, readily available, fun, and motivate behavior change. The end result was a children's video in English and Hmong language with entertaining stories and songs to teach hand washing. It was initially distributed and promoted through area libraries and family day care providers. Multiple distribution methods are now making this resource available for everyone.

Objectives:

The Department staff worked to (1) develop a collaboration including authors of curriculum materials and the author of a children's book, librarians, professional experts on video taping, State Epidemiologist, Hmong health education, and Hmong early childhood educator; (2) develop a professional, creative, culturally sensitive video using the *"Why, How, and When"* curriculum; (3) provide 60 copies of the video to local libraries, Early Childhood and Family Education programs, and participants in the collaboration.

Role of Local Health Department:

Health department public health nursing staff have overseen this effort for the three years of its existence. Health department attorney services were also made available to the project.

Barriers Encountered:	**Strategies to Overcome:**
Setting up a collaboration of persons from both profit, nonprofit and government was difficult and time consuming. The original grant called for 60 copies being prepared. Demand quickly eliminated this inventory forcing the staff to find another way to develop copies. Staff had to get specific copyrights for the materials in order to control for only nonprofit copying and distribution.	Collaboration, while time consuming, was identified as a way to assure cultural diversity and to produce a better product than any one person or organization could do alone. Staff found a resource in a local children's foundation and program that could copy the videos and charge only the actual cost of the copying. This established the cost of the video at $10 and significantly increased people's access to it. Staff sought our legal assistance on the copyright issues to assure that someone would not take the video and sell it for a profit.

Key Partners/ Collaborators:

Book publisher, Minneapolis Health Department, State Health Department, Wilder Foundation, curriculum author, book author, Saint Paul libraries, Ramsey County libraries, child care providers, and family day care associations.

Accomplishments:

1) Currently 1,500 copies of the video are in distribution or in libraries in the urban area. 2) Feedback from users such as family day care providers has been overwhelmingly positive. 3) The video and curriculum have been picked up by the State for use in packets for family day care providers which will reach an additional 11,500 homes.

Lessons Learned:

1) Collaborations involving for profit entities as well as nonprofit and governments are more difficult to implement and reach outcomes. 2) If you build a quality video, they will come!

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Pinellas Square Mall/Outreach Clinic

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:
Culturally appropriate health education materials/programs.
Identify high-risk/hard-to-reach populations.
Provide, arrange, administer direct services.

MCH Initiatives:
Preconception promotion.
Family Planning.
Breast/cervical cancer.
Teen pregnancy.
Communicable diseases.
One-stop shopping locations.

Funding Sources:

Budget: Not reported.

City/County/Local government funds.

Description:

The Pinellas County Health Department started the teen clinic in December of 1995, with the cooperation of the management of the Pinellas Square Mall Shopping Center. The clinic has grown from one to three weekday afternoons and is strictly for "walk-ins," male and female. It is directed by Dr. Paulette Thompson, a Family Practitioner, who is also the Director of the Health Department's Family Health Division. Staff includes an ARNP, a STOP counselor, and a Health Support Technician. As clients wait to be seen, educational films are shown in the space formerly occupied by a jewelry store. The examination room is nearby in a private locked office. A complete women's health physical examination, including a PAP test and sexually transmitted disease testing, is performed. As it cannot be anticipated how many teens will show up on a busy day, there is the option of providing oral contraceptions or Depo-Provera after a "brief exam," with the complete detailed physical examination planned for a later date. Other services offered include: HIV testing, anonymous and confidential, pregnancy testing and referral, breast self-examination demonstration, STD, and WIC services.

Objectives:

1) To service 200 teens, family planning clients in a comfortable, non-threatening environment. 2) To offer HIV testing for teens, confidential and anonymous, male and female, at a location easily accessible to teens; the goal being 100 HIV tests each quarter. 3) WIC - serve clients in the community, reduce over-crowded clinics, decrease waiting time (400 participants a month). 4) The staff is currently serving 423 participants per month and clinic service is available one day per week (Tuesdays only, 10:30-4:30). However, due to the popularity of this site, its caseload continues to grow. During the month of May, 1997, WIC provided services to 51 pregnant females, 27 breast feeding mothers, 34 postpartum clients, 124 infants and 187 children. This is approximately 2.7% of total population that is being served county wide.

Role of Local Health Department:

The Pinellas County Health Department's Administrative staff met frequently with Mall Management staff to plan and implement teen services. The project cost is a joint effort, the Mall making space available at no cost to the Health Department who provided utilities, management, total staffing, and management of clinic services.

Barriers Encountered:	Strategies to Overcome:
WIC is experiencing a staffing shortage due to budgetary constraints. The constraints have made it difficult to staff this location but the teams continue to provide quality services and valuable information to participants and their families. More teens are walking in for services than can be served by clinic staff.	Both oral contraceptives and Depo-Provera can be prescribed after a "brief exam," thereby shortening clinic visits and increasing the ability to serve greater numbers. The overflow clients are referred to a more traditional site for services.

Key Partners/ Collaborators:

Not reported

Accomplishments:

The number of clients served has increased from 29 the first quarter the Mall Clinic opened, to 463 served in the most recent quarter. The Pinellas Square Mall Management is happy having the teen clinic based there as its brings in more customers. With the August 1998 opening of the Mall's ice-skating rink, it is anticipated that many more teens will have access to Health Department Mall Clinic services. The program was able to increase caseload by 11.4% within two years due to increased satellite sites and services within the community that are accessible and convenient. The most obvious accomplishment is the program is more accessible to the community. By co-locating our program with a women's health/family planning clinic, we see more hard-to-locate families. We are also able to refer for family planning and able to case manage with the nurse practitioner for those families with greater needs. The same is true for the immunization clinic and WIC. It has been an asset to have all the programs in one central non-threatening location. An additional accomplishment has been in the area of community education. The Mall has allowed us to use some of the empty stores for public forums on Welfare Reform, and presentations on parenting, gang awareness, baby basics, and developmental play groups.

Lessons Learned:

1) Teens will utilize a Family Planning Clinic that is easily accessible and provides privacy. 2) Teen male partners frequently accompany the Family Planner and will usually participate in the educational portion of the visit. 3) Male partners of Family Planning clients, when given the list of Mall Clinic services, frequently request HIV and other STD testing for themselves. 4) In about 50% of teen visits, the teen's mother accompanies her to the Mall Clinic and is included (at client's request) in the educational process. 5) Referrals to the Mall Teen Clinic are made by appointment clerks at the three Health Department Centers, middle school and high school counselors and nurses. 6) Free Clinic, clients referring and transporting friends, and counselors at special school programs for students at high-risk for dropping out. 7) Community networking is very important when expanding the Agency services. Many of the community agencies are willing to assist with promoting various programs in the community to the people who live in the area. 8) Services which are offered in the community do not have a negative stigma attached. We have noticed positive change in the clients' attitude in the satellite sites. 9) The team has established a good working rapport with the various agencies and clients. 10) Having a community health/outreach program in a local mall setting has been an absolute success. It has been beneficial to the declining mall as the program increased traffic for the merchants. 11) Initially, fear was demonstrated by some of the merchants as to "what type of people are going to be using the services." Once they realized that their own employees and existing customers were utilizing the services as well as new clientele, the program was warmly welcomed and accepted.

Dental Health Services

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Hotlines, print materials, media campaigns. Ombudsman services. Pediatric risk adjustment methods & payment mechanisms.	Prenatal care. Dental programs. Overcoming cultural barriers. Expanding private sector links. Securing MCH assistance. Building coalitions & partnerships.

Funding Sources:

Budget: $50,000 / 6 months

City/County/Local government funds.
MCH block grant funds.
Private source(s): Intermountain Health Care
Other Federal funds.
Third party reimbursement (Medicaid, insurance)

Description:

Access to dental care remains illusive to uninsured and underinsured Utahn's. Although the implementation of managed care brought a promise of increased access, the reality is that not all dentists will take Medicaid. For the 10,000 Native Americans living along the Wasatch front in Utah, maneuvering the bureaucracy of medical and dental care, unsympathetic to their cultural needs, is often overwhelming. When poor financial management was forcing closure of the struggling Indian Health Clinic, the Salt Lake City-County Health Department intervened to provide interim management and find additional partners to fund the relocation of services.

Objectives:

1) Some patients will maintain continuity of care. 2) The capacity for seeing dental patients will be expanded to all populations. 3) Migrant Head Start will have access to a dentist. 4) The possibility exists to hire another dentist and dental resident.

Role of Local Health Department:

The health department provided management oversight for the transition services while finding partners for future collaboration. This effort of coming around the table to save a valuable community service has opened doors for other partnerships.

Barriers Encountered:	**Strategies to Overcome:**
Maintaining patient contact. Ability to maneuver each unique system. Time and money.	Some personal contacts, but many are lost. Persistence and a sense of humor.

Key Partners/ Collaborators:

Indian Health Services; Utah Department of Health: Intermountain Health Care; Community Health Centers

Accomplishments:

1) The dentist remained in business and expanded services to migrant head start children. 2) The Community Health Center system has hired the dentist to run their first dental health program. 3) Expansion is a possibility by using multiple funding sources and the University Medical School dental residents.

Lessons Learned:

1) When we aren't providing the services, the role of convener is less threatening. 2) Collaborations take work. 3) Be vocal about needs; help comes in many forms. 4) Patience

Competency Testing

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Provide infrastructure/capacity for MCH functions. Staff training.	Staff training.

Funding Sources:

Budget: Not reported.

MCH block grant funds.

Description:

The San Antonio Metropolitan Health District Bureau of Family Health Services initiated annual written competency testing appropriate to public health for all Registered Nurses within the Nursing Division July, 1996. The competency testing allows the agency to assess deficiencies in the professional staff's knowledge base in women's and children's health in the application of protocols and policies in their area of primary practice. Tests are developed in maternity, family planning, child health and immunizations. Employee deficiencies are evaluated on an individual basis and educational in services/offerings topics are developed to enhance knowledge deficit. Training needs assessments are a component of the agency's quality assurance plan.

Objectives:

EXPECTED OUTCOME: All registered nurses within the Nursing Division will demonstrate a competent knowledge base in assimilation and application of written protocols and policies. The goals of annual competency testing are the assurance of provision of ongoing quality of care and identification of problems in either specific knowledge or skill levels.

OUTCOMES MEASURES BEING USED TO EVALUATE THE ACTIVITY: Chart reviews to assess nursing documentation and correct protocol management to evaluate the ongoing quality of care and to identify problems in either specific knowledge or skill levels, and self assessed training needs by staff for development programs via an education needs survey tool.

Role of Local Health Department:

Seminars, monthly in-service and other educational opportunities along with reference materials have been supported. Planning, implementation and evaluation has primarily been the role of the personnel from the bureau's staff development committee in particular with the area supervisors and clinic managers.

Barriers Encountered:	**Strategies to Overcome:**
Establishing agreeable development of test questions in all areas of testing. Acceptance on behalf of the registered nurses whose perception was that the testing would be punitive.	Select staff were asked to test in their area of expertise to evaluate for test question clarity and content. Testing acceptance by the registered nurses was less threatening the second year. Prospective employees are informed of annual competency testing measures at their pre-employment interviews.

Key Partners/ Collaborators:

The personnel from the Bureau of Family Health Services responsible for this activity have been the Women's and Child Health

Medical Directors, Nursing Program Manager and Assistant Nursing Program Manager, the Women's and Child Health Nursing Coordinators and Nurse Practitioners.

Accomplishments:

Supervisor initiation of clinical observation of staff/patient encounter observations with written documentation and discussion with employee of direct observation findings and inclusion of the employee in development of a documented plan for improvement measures.

Lessons Learned:

Changes that necessitate improvement in the delivery of quality care required coordinated efforts of multiple staff at varying staff levels with support from both administrative and clinical staff. Initiation of monthly meetings with appropriate clinical "grass root" managers for implementation of new or revised protocols/policies along with input of those same staff members in the development and evaluation of materials and forms has been beneficial and well received by all. Coordinated team efforts build team spirit.

Elaboration of Model Hospital Policies Regarding Breastfeeding

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No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Promote compatible, integrated service system initiatives. Development of models. Certification & monitoring provider compliance. Assessment of provider reports regarding process and outcomes.	Breastfeeding/nutrition/WIC. Building coalitions & partnerships.

Funding Sources:

Budget: $9,000

MCH block grant funds
Private source(s). Staff from various institutions donated time in the research, development and publication of these policies.

Description:

The San Bernardino County Breastfeeding Task Force, chaired by the San Bernardino County Department of Public Health MCH Director, elected to write model hospital policies. A committee of the Task Force, chaired by Carol Melcher, Coordinator for the Regional Perinatal Programs, crafted the policies. These were reviewed by the entire Task force, MCH and WIC personnel of the California Department of Health Services, and WellStart International.

Regional Perinatal Programs and Task Force members are distributing the policies, along with hospital self-assessment tools from The Baby Friendly Hospital Initiative. These will be used to promote accomplishment of the Task Force's objectives of having two Baby Friendly hospitals in San Bernardino County by July 1998.

Objectives:

Hospital achieving "Baby Friendly" status

Role of Local Health Department:

1) The MCH medical officer, with the assistance of the County's WIC Breastfeeding Coordinator inaugurated the task force and guided the group in the selection of objectives.
2) Health educators and lactation educators from the Department participated in the drafting of policies.

Barriers Encountered:	**Strategies to Overcome:**
Getting agreement and approval from multiple involved agencies.	Patience and flexibility.

Key Partners/ Collaborators:

Regional Perinatal Programs, State Department of Health Services, MCH and WIC Branches, Area Lactation Consultants and Educators, Hospital L&D, Postpartum, and Nursery Supervisors from throughout the county.

Accomplishments:

Policies have been written, approved, published and distributed.

Lessons Learned:

Collaboration works!

Managed Care Initiative

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No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Review process for ped LT care admissions, CSHCN home services.	Managed care initiatives.

Funding Sources:

Budget: Not reported.

City/County/Local government funds.
General state funds.
MCH block grant funds.
Private source(s).
Third party reimbursement (Medicaid, insurance)

Description:

The State mandated all AFDC-linked Medi-Cal recipients to be enrolled into managed care. The model is a unique pilot called Healthy San Diego (HSD).

The design of HSD has come from a three year, collaborative process involving all key local stakeholders and operates on consensus principles.

County Department of Health Services (DHS) is not a direct service provider and not part of any managed care plan; therefore, it acts as a neutral facilitator balancing out priorities of stakeholders and negotiates for HSD with the State DHS. Mandatory enrollment starts 7-98 and State DHS will directly contract with 6 to 8 plans locally.

Objectives:

1) Lower rate of plan mandatory assignment and disenrollment.
2) Consumer that can better use managed care and make plan selection.
3) Less disrupted patient-provider relationships.
4) Good referral system/communication between Plan providers and public health programs and "carved out" Medi-Cal programs.
5) Partnership of HSD with community to monitor population health status and jointly address health problems.

Role of Local Health Department:

Staffed all meetings and do needed follow-up.
Work with State DHS, legislature and local stakeholders and their State lobbying organizations. Organize County staff to respond to new system.
Act as spokesperson to media and other interested parties.
Work "behind the scenes" to develop consensus.
"Troubleshoot."

Barriers Encountered:	**Strategies to Overcome:**
State DHS lack of cooperation. Low capitated reimbursement rate. Difficulty of obtaining consensus.	All local stakeholders in agreement. Advocate to redo allocation to California. Time, effort and building trust.

Key Partners/ Collaborators:

Consumer and other advocacy organizations; Community Clinics; University Hospital; Children's Hospital; Hospital Council; Medical Society; traditional Medi-Cal providers; dental, pharmacy, optometry, etc. - provider organizations; taxpayer/voter associations; Chamber of Commerce; local foundation; universities.

Accomplishments:

1) "Local standards" specific to Plan contracts in HSD agreed to by local stakeholders and by State, include protection of traditional providers.
2) Enrollment counseling done by County DHS staff.
3) Local Quality Improvement (QI) Subcommittee currently working on: development of consumer-friendly Plan Report Card, agreement on mutual QI studies and indicators to be monitored across all Plans, mechanisms for cooperation of Plans with Public Health Programs, and miscellaneous cooperative projects amongst Plans.

Lessons Learned:

In order to carry out core public functions it is much more effective not to be a direct service provider and compete for funds with the providers with whom you have to "assess, plan and assure."
The political process is as important as the "content" of what you're trying to do.
It is in the best interest of Plans to be "ahead of the curve" and partner with Public Health to produce report cards, locally monitor system performance and outcomes, and participate in community level interventions.

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Regional Homeless Perinatal Collaboration

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions: Maternal, fetal/infant, child death reviews. Culturally appropriate health education materials/programs. Assessment of provider reports regarding process and outcomes. Prepare, publish, and distribute reports. Develop & promote MCH agenda & YR2000 National Objectives. Support of continuing education. Profiles of provider attitudes, knowledge & practices.	**MCH Initiatives:** Prenatal care. Other outreach activities. Increasing access to Medicaid. Building coalitions & partnerships.

Funding Sources:

Budget: $3,000

City/County/Local government funds.
MCH block grant funds.
Other: Registration fee to cover the cost of food for the conference.

Description:

The formation of the Regional Homeless Perinatal Collaboration was highlighted by the convening of the First Regional Bay Area Conference on Homeless Perinatal Issues May 16, 1997 at the Oakland, CA YWCA. The conference was the result of a 6 month planning process involving regional representatives from the following counties: Alameda, Contra Costa, Marin, San Mateo, Santa Clara, and the City of Berkeley. The collaboration is spearheaded by San Francisco Maternal and Child Health Office, and the conference was supported through the State of California MCH Allocation.

The conference began the process of networking, the identification of common issues in the region which affect homeless pregnant women, the exchange of information on strengthening families, and advocacy.

Objectives:

1) The establishment of a regional collaborative of CBOs, MCH programs, and funders.
2) A regional resource guide.
3) Annual conferences for Homeless Perinatal issues.

Role of Local Health Department:

The lead agency in the collaborative and provided the staff support for the convening of all meetings and the planning for the conference.

Barriers Encountered: Staff support for the collaborative.	**Strategies to Overcome:** Request for funding beyond the current MCAH allocation. Increase county funding to support effort.

Key Partners/ Collaborators:

Homeless Perinatal Program in San Francisco; Homeless Programs in the following counties: Alameda, Berkeley City, Marin, Contra Costa, San Mateo, and Santa Clara; Maternal and Child Health Programs in the above mentioned counties; and community based organizations who work with homeless families.

Accomplishments:

160 participants attended the first conference.
County task forces were formed to work on local issues.
The regional collaboration is continuing.

Lessons Learned:

We were very pleased with the response of support from other counties in planning for the conference. The work load was shared and the evaluations reflected the regional interest and support. I would encourage others to continue the collaborative effort that seems to be reflected in other profiles.

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County-wide Health Assessment

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Replicated Elsewhere?
Yes. San Diego County, CA

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Develop tools standardizing data collection, analysis, reporting Analysis of demographics, economic status, behaviors, health status. Assessment of provider reports regarding process and outcomes. Public advocacy for legislation & resources. Special studies. Ombudsman services.	Expanding private sector links. Clergy & health connections. School & health connections. Increasing social support. Building coalitions & partnerships.

Funding Sources:

Budget: $150,000

City/County/Local government funds.
Private source(s): Proprietary and not-for-profit hospitals and other interested community organizations such as the March of Dimes, United Way, etc.

Description:

Assessment is one of the core Public Health functions. Historically, most assessment activities performed by Orange County's local health department have been the collection and analysis of secondary data in an attempt to document the community's health status and determine priorities. Other community organizations, including the March of Dimes, United Way, local hospitals, and universities have also conducted periodic assessments of the community. The result has been fragmentation, incomplete data, duplication, unnecessary cost, and the absence of a replicable methodology with which to compare data over time. In April of this year, the Health Care Association of Southern California (the local hospital council) was approached by the local health department to spearhead an effort to conduct a comprehensive, County-wide health assessment of Orange County using the Assessment Protocol for Excellent in Public Health (APEX PH).

Objectives:

It is expected that over the next 18 months a Work Group Steering Committee, composed of representatives of all major stakeholder groups, will plan and execute a comprehensive, County-wide health assessment of Orange County using both primary and secondary data. Armed with the data generated from the assessment, the local not-for-profit hospitals will be able to develop and submit their community benefit plans to the State. Based on the data, an objective priority setting process will take place regarding the health issues of the county, and subsequent work groups representative of stakeholders will develop action plans around these issues. Finally, it is anticipated that the process will result in the decision to conduct a county-wide health assessment every three years.

Role of Local Health Department:

The local health department engaged in low-level promotion and research efforts related to conducting community-wide health assessments for two years and then initiated a formal proposal to the hospital council in April. The local health department co-chairs the Work Group Steering Committee along with a representative of a not-for-profit hospital. The local health department's research center will be the lead entity in the collection and analysis of secondary data. The local health department will be a sustaining influence in an effort to ensure that the assessment process evolves into priority setting and action plan development phases, and that the overall process is continued on a three year cycle.

Barriers Encountered:	**Strategies to Overcome:**
Lack of resources. Competition among hospitals and community-based organizations. Suspicion about the County's motivations. Coordination of an effort involving so many organizations and entities.	Significant new County resources are being committed to effort, and hospitals agreed to pool their resources to make it happen. Not-for-profit hospitals see this process as the most cost effective and efficient manner in which to satisfy their statutory requirements; proprietary hospitals view this as good public relations. Other organizations see the effort as building momentum and they don't want to be excluded from what could be a very significant and successful undertaking.

Key Partners/ Collaborators:

The key partner and collaborator has been the Health Care Association of Southern California, the local hospital council.

Accomplishments:

1) Agreement on the part of the Health Care Association of Southern California to participate in and promote the county wide health assessment among its members, 2) Agreement by all not-for-profit and proprietary hospitals within Orange County to participate in the assessment and its financing, 3) Agreement to model the assessment process on APEX PH, 4) Decision by the Orange County Board of Supervisors to appropriate nearly $250,000 to support the research and networking infrastructure necessary to conduct and sustain this effort, 5) Contribution of $70,000 from the local Medicaid contractor to help underwrite the cost of primary data collection efforts (telephone survey), 6) Receipt of a $213,000 grant from The California Endowment to support conducting and sustaining the health assessment process, 7) Receipt of a contribution of $5,000 from the local chapter of the March of Dimes to support the assessment process, 8) Publication of a monthly newsletter about the County wide health assessment being distributed to over 700 individuals and organizations as well as being posted on the County wide Health Assessment website--www.oc.ca.gov/ochna.

Lessons Learned:

1) Local health departments need the participation of a wide range of community stakeholders to address the health care needs of their community, and 2) timing is everything -- there are many good ideas, the key is finding the right moment with a receptive audience.

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Childhood Injury Prevention Workshop

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Analysis of demographics, economic status, behaviors, health status. Culturally appropriate health education materials/programs. Assessment of provider reports regarding process and outcomes. Develop & promote MCH agenda & YR2000 National Objectives.	Injury (including child abuse).

Funding Sources:

Budget: $1,500

MCH block grant funds.
Private source(s): Private Foundation
Other: Health Maintenance Organization

Description:

Because injury is the leading cause of death and morbidity for Sonoma County children and there have been no strategic planning efforts to prevent childhood injury, the County of Sonoma Department of Health Services Maternal Child and Adolescent Health (MCAH) Program and the Sonoma County MCAH Health Advisory Board planned and convened the first community Childhood Injury Prevention Workshop on May 5, 1997. Approximately 90 health and human service professionals and advocates participated in a day of activities centered on injuries to children that included: 1) keynote presentation of injuries common to specific age groups of children, 2) local data on injuries to children, 3) poster session highlighting local childhood injury prevention resources and programs, 4) speakers on three specific injuries of high concern or impact to our community: motor vehicle crashes, adolescent suicide, and child abuse, and 4) small work groups listed an inventory of current local prevention efforts and prevention strategies that could be considered for local action.

Objectives:

After participating in the workshop providers would be able to: 1) become familiar with the local data on a variety of childhood injuries, 2) understand which childhood injuries are common to specific age groups or environmental factors, 3) explore strategies and models for prevention of childhood injuries, 4) identify existing injury prevention efforts in Sonoma County, and 5) plan ways to integrate or enhance injury prevention in their programs.

Each workshop attendee was encouraged to complete an evaluation at the end of the workshop to evaluate whether or not the workshop provided them with important information on childhood injuries and prevention strategies.

Role of Local Health Department:

The Sonoma County Department of Health Services (DHS) initially identified the need in our county to address childhood injury; DHS then provided leadership in planning and implementing the Childhood Injury Prevention Workshop and provided structure and support for the SAFE KIDS coalition and suicide prevention committees to meet following the workshop.

Barriers Encountered:	**Strategies to Overcome:**
Obtaining injury data especially for school and fall injuries. Difficulty selecting 2-4 types of childhood injuries to focus on during the workshop.	We postponed getting school, recreational, and fall injury data for the workshop and plan to get technical assistance in researching existing data sources this year. The planning committee used criteria and reviewed data to select the injury types.

Key Partners/ Collaborators:

The Sonoma County Maternal, Child and Adolescent Health Advisory Board partnered with Department of Health Services in planning and convening the workshop.
Kaiser Permanente, Health Plan of the Redwoods (local HMO) and Sonoma County Academic Foundation for Excellent in Medicine (local non-profit) sponsored the workshop.

Accomplishments:

From the initial childhood injury prevention workshop the following has been accomplished: 1) a local SAFE KIDS coalition (sponsored by the Children's National Medical Center) has formed to implement child injury prevention projects; 2) a county-wide adolescent suicide prevention committee has formed to develop an action plan to train providers who then could act as local experts in educating the public away from misconceptions about suicide; 3) the local child abuse prevention council's membership has been expanded; 4) a report of local childhood injury data was published; and 5) a list of current prevention resources and many potential prevention strategies were generated.

Lessons Learned:

We learned that our community was unaware of the prevalence of childhood injuries and of existing prevention programs. Workshop participants appreciated the opportunity to hear child injury experts and to network with each other during the workshop. Many health care providers were already working on preventing a specific injury type within their individual programs. Agencies found that they could benefit from knowing what other agencies are doing in prevention to avoid duplication of effort or to share what they had developed.

We also learned that an injury prevention workshop requires a great deal of planning and work to prepare participants with information such as injury data, types of injuries common to specific age groups of children and environments, and model prevention strategies. Information forms a foundation from which workshop attendees can provide ideas for prevention strategies during the workshop.

Additionally, we learned that school, recreational and fall injury data was difficult to collect and that we needed to research existing data sources or develop a new data source for these injuries. We found that we needed to ask for special data reports from hospitalized injury data to determine the specific causes of fall injuries.

Teen Plus

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:
Hotlines, print materials, media campaigns.
Culturally appropriate health education materials/programs.
Assessment of provider reports regarding process and outcomes.
Provide infrastructure/capacity for MCH functions.
Laboratory capacity.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.

MCH Initiatives:
Family Planning.
Low birthweight/infant mortality.
Teen pregnancy.
Teen parenting.
Other outreach activities.
Building coalitions & partnerships.

Funding Sources:

Budget: $150,000

Department of Health and Human Services, Region IV and Emory University RTC.

Description:

Teen Plus Program implemented July, 1997. Program proposes to reduce the number of teenage pregnancies by utilizing non-traditional clinics and employing aggressive interventions strategies to prevent first and second pregnancies and to decrease the need for public assistance through employment, job training and education.

Objectives:

1. Decrease in the number of unintended pregnancies in Chatham County. 2. Improved compliance with clinic visits by TANF applicants/recipients. 3. Enhanced coordination of services between Public Health and DFCS. 4. Reduction in number of families dependent on public assistance. 5. Reductions in number of teens unable to complete high school due to unintended pregnancy.

Role of Local Health Department:

Health Department staff in collaboration with Department of Family and Children Services.

Barriers Encountered:
Low self esteem of teens.
Lack of tracking system.
Large number of teens that are sexually active before seeking reproductive health care services.

Strategies to Overcome:
Education materials being developed.
Referral form and tracking system being developed.
Age appropriate literature being developed for distribution.
Staff at clinic sites being educated about program.

Key Partners/ Collaborators:

Women's Health Coordinator, Adolescent Health Coordinator, Family Resource Clinic Supervisor, DFCS Supervisor

Accomplishments:

Staff consisting of nurse practitioner, outreach worker and clerical position have been employed. Program being implemented. Note that the Outreach Worker hired for this program was a DFCS recipient selected from a list of possible candidates submitted by the Chatham County DFCS Department.

Lessons Learned:

The grant application process was a rewarding experience. It was the first time that the local departments of Public Health and DFCS had worked together Collaboratively in the pursuit of grant monies. Representatives from the two agencies met on several occasions to define the goals and objectives for the program. There was a lot of "give and take" between the agencies in an effort to develop strategies that would be reflective of both PH and DFCS in accomplishing these goals and objectives.

Increase Skills Among Caregivers and Teachers of Children with FAS and Related Effects

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No

Updated Profile?

Essential MCH Functions:
Culturally appropriate health education materials/programs.
Public advocacy for legislation & resources.
Special studies.
Laboratory capacity.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.
Universal newborn screening programs.

MCH Initiatives:
Home visiting.
Children with special needs.
School-linked/based services.
School & health connections.
Increasing social support.
Staff training.
Building coalitions & partnerships.
Building MCH data capacity.

Funding Sources:

Budget: Not reported.

MCH block grant funds.
Other: Center for Disease Control Disabilities Prevention Project Grant

Description:

In an urban public health department setting, an innovative public health nurse/education specialist team intervention for the caregivers and teachers of children diagnosed with fetal alcohol syndrome (FAS) and related effects was implemented and evaluated from June, 1996 to November, 1997. The program was carried out within the Department's Fetal Alcohol Syndrome Prevention Program with activities targeting primary, secondary and tertiary prevention. Primary prevention included health education targeting alcohol use during pregnancy, a resource/referral service, and a community task force. Secondary prevention was accomplished through health education targeting early diagnosis and treatment, a pilot FAS/FAE screening study which was integrated into well child exams for selected children, and a newly established FAS/FAE diagnostic clinic. Finally, tertiary prevention activities included health education on effective intervention, and the nursing/education specialist intervention project described below.

The pilot home and school visitation model employed team advocacy strategies to enhance care giver coping skills and teacher sense of competence in maximizing the success of the children with FAS and FAG. The public health nursing and education specialist intervention strategies, which took place over a 4 to 6 month period, were largely cognitive, behavioral, and educational in focus. They were developed through a literature review and through consultation with members of the intervention team and caregivers of children with FAS and FAE. The nursing strategies are presented in their entirety as *Public Health Nursing and Social Work Practice Guidelines* in the Model for Children and Young Adults with FAS and FAE, by Rose Quinby of the Seattle-King County Department of Public Health.

Objectives:

Program evaluation outcome measures included the following:
1) Weekly nursing care plans were reviewed and summarized by an independent evaluator to measure the frequency of each intervention activity.
2) Nursing and educational specialist clinical progress notes were coded and evaluated to obtain intervention content and process information. The QSR NUD IST Qualitative Data Analysis Software for Research Professionals was used to code and analyze the qualitative data.
3) Semi-structured and pre-post interviews with intervention and comparison group caregivers were conducted by an independent evaluator. The interview responses were also coded and the QSR NUD IST Qualitative Data Analysis Software was used to analyze the interview responses.
4) Pre and post administration of a teacher FAS/FAE knowledge survey and a series of questions to assess comfort level with

working in areas related to the intervention were used to assess the education intervention.
5) Pre and post administration of the short form of the Parent Stress Inventory (PSI) (Albidin, 1995).
6) The Parenting Sense of Competence measure (Kazak and Linney, 1983) was administered pre and post intervention.
7) The Family Resources Measure, adapted from a previous measure, was used to assess the self-perceived adequacy of caregiver resources in the form of time, money and energy. It was administered pre and post intervention.

Role of Local Health Department:

The health department created, implemented, and evaluated the project. The Project Coordinator, Evaluator and Public Health Nurses are all regular employees of the department. The FAS Educational Specialists were hired as temporary employees for the duration of the study, allowing a transfer of knowledge and skills that have now become a part of the ongoing work of the department.

Barriers Encountered:	**Strategies to Overcome:**
Initial identification of new cases through a health department/state foster care department inter-agency protocol proved to be complex and time consuming. Referral rates were inadequate.	This method of case identification had to be abandoned, as it would have been impossible to obtain enough cases to complete the project within the grant timelines. A new method was put in place which involved contacting families who were previously diagnosed through the University of Washington FAS Clinic.
Carrying out a thorough evaluation of a special population in a public health practice setting requires a significant commitment of time, staff and resources, but pays for itself many times over.	Protocols for conducting strong evaluation in a practice setting need to be established at the start of the study. Differences between research and practice settings need to be negotiated on an ongoing basis. The value of supplementing the traditional public health evaluation focus on large population-based problems with smaller, high-need, special populations need to emphasized repeatedly to decision makers with the use of data. Grant funding was also acquired to fund the project.

Key Partners/ Collaborators:

Key collaborators include the following: 1) The Washington State FAS Diagnostic and Prevention Network referred many of the caregivers for the project, and is providing diagnostic training to health department pediatricians, nurses and community professionals for the health department clinic; 2) The Washington State Department of Health assisted with grant acquisition, project support, funding, and management. 3) The Fetal Alcohol Syndrome Family Resource Institute provided information and support for the nurses and caregivers.

Accomplishments:

Nearly all of the caregivers expressed in the parent interviews that the services delivered by the Public Health Nurse and the Education Specialist were very useful and supportive. Specific information about what aspects of the services were helpful will be available in October, 1997. The level of skill and competence of the Public Health Nurses in working with the caregivers of children with FAS or FAE was greatly enhanced, especially by the guidance education they received from the Education Specialists who had special expertise in this area. An informal network of nursing expertise has been established in the three health clinics where the nurses work, as a result of this study. The trained nurses have been sought out by their colleagues for consultation on issues of FAS or FAE.

Lessons Learned:

We have learned in depth about the multiple needs of caregivers and teachers of children with FAS or FAE, and the commensurate high impact on community and family health. The mission of Public Health intervention should be broad enough to include the needs of populations which may not occur with the same frequency as populations traditionally focused upon. Conducting evaluations in the public health practice setting results in a more immediate dissemination [illegible] evaluation results to practitioners, and exciting opportunities for practitioner self-evaluation.

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Centralized Immunization Registry

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives**:
Develop tools standardizing data collection, analysis, reporting Community perceptions or health problems/needs. Laboratory capacity.	Immunization. Communicable diseases.

Funding Sources:

Budget: Still being determined.

City/County/Local government funds.
MCH block grant funds.
Private source(s): Private doctors, Other:
Health Care Plans, community businesses

Description:

Six months ago community members of Spokane's Health Improvement Partnership expressed a desire to work with the Health District to develop a county-wide immunization registry. Issues addressed were: lack of centralized immunization registry system, inconsistent methods of tracking information, and inability to access information after usual work hours.

For the last three months meeting with key members of the Health Improvement Partnership has moved the process through framing the issue and assessing basic need to implement. We have begun to look at what is available and site visits are planned to see up and running systems.

Objectives:

1) Up-to-date county-wide immunization registry.
2) Up-to-date data on the immunization status of children up to age 18 in the County.
3) Closer working relationship with Health Care Providers.
4) 24-hour access to immunization status of children by Health Care Providers and parents.
5) Linkage of autodialer to registry system.

Role of Local Health Department:

The Health District has been the catalyst in reaching out to our Community Health Improvement Partnership. We are willing to work with and support whatever entity the community-based workgroup recommends at the immunization registry's site.

Barriers Encountered:	**Strategies to Overcome:**
All Health Care Providers "buying into process." Funds for compatible software and hardware. Potential additional staff workload in Doctor's office to input immunization. Potential turf concerns around location of Registry.	Process community driven vs. Health District driven. Key physicians being brought on as well as the Plans. Community Health Partnership talking to businesses and plans to contribute dollars. Office staff will be asked for input on options. Health District has assumed a neutral role. The probability is high that we will be asked to house the registry system.

Key Partners/ Collaborators:

Health Plans (5), pharmaceutical companies, Health Improvement Partnership, local hospitals, local physicians (pediatricians, family practitioners), state MCH staff, and Washington Hospital Council.

Accomplishments:

"Don't Hang Up" campaign has been completed; autodialer system contacts 300 homes per work day.
A powerful community workgroup has convened to "make happen" a community-wide Immunization Registry.

Lessons Learned:

The community process takes time, care and nurturing. We have to be willing to let the community players decide on the lead agency to secure buy-in and minimize turf issues. Health Care Plans, providers and hospitals don't always see the Health District as neutral even though we think of ourselves as neutral. This has necessitated re-thinking our community approach.

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Public Health and Managed Care: A Collaborative of Upstate New York

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Provide outreach services. Managed Care model contract & access issues. Identify & report access barriers.	Increasing access to Medicaid.

Funding Sources:

Budget: Not reported.

City/County/Local government funds.
Other: Medicaid Managed Care Contract fees
charges for billable services rendered.

Description:

The Onondaga County Health Department has joined with four Managed Care Organizations to develop a comprehensive system that integrates public health with managed care. Support for this integration comes from the Onondaga County Department of Social Services Medicaid Managed Care Unit and has the potential of integrating what is currently a system of fragmented care in which families see multiple providers to receive preventive and curative services, including prenatal, postpartum, immunization, lead screening and well-child care. The lack of experience of Managed Care Organizations to work successfully with high risk/disadvantaged populations where extra efforts are often needed, including outreach and home visitation will be augmented by the expertise of the Health Department.

Objectives:

1) To monitor the provision of preventive services among enrolled populations.
2) To work with managed care to address the needs of the high risk/disadvantaged populations through outreach and home visitations by public health teams (nursing, social work community health workers and outreach workers)
3) To provide increased access to over 2,000 primary care physicians and specialists.
4) To link managed care to Health Department preventive activities and services such as STD, TB and HIV screening, testing and follow-up services.
5) To create a quality assurance program that measures patient and provider satisfaction; prenatal, postpartum, and newborn interventions and their relationship to birth outcomes.
6) To identify and report access barriers to Health Department programs and staff, primary care providers and respective Managed Care Organizations.

Role of Local Health Department:

The Health Department senior staff met with all substantive Managed Care Organizations in the county to develop a Public Health-Managed Care Agreement that would spell out the respective responsibilities of the Health Department and each Managed Care Organization in providing public health services. After sending drafts of the proposed agreement to the MCO directors, the Commissioner and Health Department senior staff met again with each MCO serving Onondaga County to discuss the draft. The reception by all of the MCO's was enthusiastic.

This approach opens new horizons for population-based preventive activities and should result in preventive services reaching higher proportions of the high-risk population in need than previously. Implementation of preventive programs will also be possible by gaining access to Managed Care Organizations enrolled populations. Folic acid supplements to prevent neural tube defects are an example of reaching the enrolled population to provider preventive interventions.

Barriers Encountered:	Strategies to Overcome:
Knowledge deficit of providers of the services provided by the Public Health Managed Care Program. Knowledge deficit of plan case managers of the contractual agreement and services provided by the Public Health Managed Care Program. Case coordination has been time consuming and confusing for the staff, clients, primary care provider and plan representatives due to the existing plethora of services in the plan area. Billing and obtaining reimbursement for preventive services remain a challenge. Rates of reimbursement set by the New York State Department of Health remain as a financial disincentives for MCO's. Two of the MCO's have disenrolled their Medicaid Managed Care clients. These clients have been returned to the Fee for Service schedule or have been enrolled in the two remaining plans (Total Care and United Health Care).	A marketing specialist has been hired by the Health Department. A specific marketing plan that applies to health department staff, MCO staff and respective primary care providers and clients served has been developed. The implementation of this plan will be carried out in stages in order to increase the awareness of all parties involved and increase the utilization of the services by the clients served. Onondaga County Health Department and Social Service Department Administration continue their legislative activities regarding the rates of reimbursement set by the New York State Health Department. Frequent contact with the Onondaga County Department of Social Services also assists the Managed Care Office staff to handle the referrals appropriately. The outreach staff has provided excellent case finding for the MCO's members that have disconnected phones or no phones and they are reimbursing the Health Department per contractual agreement.

Key Partners/ Collaborators:

Not reported

Accomplishments:

1. All Managed Care Organizations (MCO's) agreed to exchange written letters of intent to develop an agreement with the Health Department. The MCO's enrolling Medicaid clients have signed the partnership agreements.
2. Development and distribution of a polished information package for health care providers and other community entities that describes how to obtain information and make referrals to the Onondaga County Health Department for contract services.
3. Over 200 authorized;referrals for home visits have been accomplished since February 1997.
4. Contracted MCO's have developed "trust" in the expertise and the services rendered by the Health Department's Public Health Team.
5. The Health Departments diverse staff has identified the need for MCO's to decrease the language barrier for their non-English speaking members trying to access member services.

Lessons Learned:

Communication, communication, communication....keep it up even when you think that every contractual detail has been addressed. Internal communication is just as important as external communication. Bi-weekly meetings between the Commissioner of Health, key administrators, fiscal officer, other Bureau Directors, Marketing Director and the Managed Care Office Staff are essential. Daily verbal and written communication regarding the referral and authorization process is a necessary task. Documentation is essential in the delivery of quality services and in receiving prompt reimbursement for services rendered. Spend time with the front line staff, help them to document effectively and to take credit for all of the excellent care, case coordination and referrals they are responsible for. They are the best organizational asset and marketing tool.

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Tacoma-Pierce County Asthma Prevention Partnership

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:

Develop tools standardizing data collection, analysis, reporting
Population surveys (BRFS, PRAMS, PedNSS, YRBS).
Hotlines, print materials, media campaigns.
Culturally appropriate health education materials/programs.
Laboratory capacity.
Transportation & other access-enabling services.
Monitor enrollment practices for ease of use.
Pediatric risk adjustment methods & payment mechanisms.

MCH Initiatives:

Expanded child health services.
School-linked/based services.
Overcoming cultural barriers.
School & health connections.
Other outreach activities.
Case coordination.
Building coalitions & partnerships.
Building MCH data capacity.

Funding Sources:

Budget: $60,000 for 18 months

Other: State Public Health Improvement Fund
Partnership Proposal Funds

Description:

Among children nationwide, asthma has become the most common chronic disease, the number one cause of missed school and the leading reason for hospitalization. Asthma is especially on the rise among African-Americans and children, with its rate of occurrence being highest in inner-city neighborhoods. This pilot project brings together the skills and resources of the local public health department, children's and tribal health care providers, lung association, and schools to create an efficient county wide system to increase access to health care and provide the comprehensive services needed to prevent or control asthma.

Mary Bridge Children's Hospital and Puyallup Tribal Health Authority will coordinate clinical care and asthma management services for children and their families, and refer families for follow-up with a home assessment. The Lung Association will train community volunteers and health department professionals to visit families in their homes to teach families how to recognize and reduce environmental risks associated with asthma, allergies and other respiratory system problems. Educational brochures will be redesigned and translated into appropriate languages for distribution. Schools and community-based Family Support Centers will assist in identifying, referring and providing support services for children at risk for asthma. A community advisory committee will work with project partners to assure the cultural appropriateness of training materials and outreach efforts.

Objectives:

The primary goal of the project is to reduce the incidence of asthma in our community, according to the *Healthy People 2000* goal to reduce hospitalizations for children under 15. Expected outcomes are to improve opportunities for clinical care and to conduct home environmental assessments and education to correct conditions which cause or exacerbate asthma attacks in children. It is anticipated that the project activities can be sustained beyond the grant period using a "train-the-trainer" approach, whereby expertise gained by local members of the partnership can be extended to other community partners.

Role of Local Health Department:

Lead applicant and fiscal agent for funding. Project Coordinator is an Environmental Health Assessment Specialist, joined with public health nurses, public health educators and Office of Community Assessment in a more integrated approach to community assessment, problem-solving and health promotion. Health Department is lead for developing baseline data, tracking system, process and outcome evaluation

Barriers Encountered:	Strategies to Overcome:
Funding received was 50% of requested amount	Project activities scaled back.
Multilingual, multicultural services are needed	Use of trained community volunteers and community advisory committee.
Implementing and sustaining behavior change	Follow-up with comprehensive services, to include family support.

Key Partners/ Collaborators:

Mary Bridge Children's Hospital, American Lung Association, Tacoma Public Schools, and the Puyallup Tribal Health Authority

Accomplishments:

A new partnership has developed, startup funding has been secured, planning for implementation is under way. A first task undertaken by the partnership has been to develop an effective assessment strategy related to a comprehensive system of gathering and tracking data. Training and initiation of home visits are scheduled for this fall.

Lessons Learned:

The importance of partnering with diverse community organizations to tie pieces of services together to synergistically accomplish more than any one agency can do on its own

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County Maternal and Child Health Block Grants Program

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:*
Analysis of demographics, economic status, behaviors, health status.
Develop & promote MCH agenda & YR2000 National Objectives.
Laboratory capacity.
Profiles of provider attitudes, knowledge & practices.
Implement/support education services for special MCH problems.
Newsletters, convening focus groups, advisory committees, networks.
Monitor enrollment practices for ease of use.
Development of models.
Promote compatible, integrated service system initiatives.
Identify high-risk/hard-to-reach populations.

MCH Initiatives:
Preconception promotion.
School & health connections.
Mobile clinics for outreach.
Strategic planning.
Building coalitions & partnerships.

Funding Sources:

Budget: $250,000

Other: State County Block Grants funds

Description:

The state of Arizona recently developed a mechanism for providing state funded direct maternal and child block grants to county health departments. As a local health department, we can now develop our own priorities, action plans, and service delivery methods based on locally developed information. Pima County Health Department (PCHD) convened a local Advisory Group to assist it with determining local priorities in the areas of maternal and child health. The Advisory Group is made up of consumers, maternal and child health providers, and public health nurses.

This group reviewed available data from the Pima County Health Status Report: 1995-1996 in order to establish its priority list for action. Armed with the priority list from the Advisory Group, the PCHD issued a Request for Proposals from community providers to develop programs that address the priority issues. Contracts were awarded to three providers. They are addressing the issues of preconceptual counseling, improving access to prenatal care and targeted prenatal care risk reduction programs through lay health outreach, case finding and case management.

Objectives:

1. To develop local solutions to specific neighborhood level access to care problems for women and children. Using a results hierarchy model for evaluation, projects are measuring behavioral and knowledge base changes of all involved (consumers, outreach lay health workers, and clinical providers).

2. To facilitate improved coordination among local service providers through participation in both the advisory group and through collaborative efforts to design service delivery systems. Improved coordination is being monitored through the make up and activities of the community advisory group. Broad based membership with ongoing advisory direction to the PCHD, and thus, to the subcontractors will show the level of coordinated effort on a local level.

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Role of Local Health Department:

PCHD acts as the facilitator and staff to the Advisory Group. Staff provide local and state data regarding maternal and child health, facilitate meetings, and offer what ever other help is needed. The Advisory Group becomes the local advisory expert in maternal and child health, and gives PCHD advisory direction in designing systems. Using state funds, the PCHD pays for the development and implementation of services designed by local providers as suggested by the Advisory Group. The PCHD's other role in this grass roots type of planning has been to support community development efforts in many neighborhoods throughout Pima County. Community development activities are the major force behind many collaborative health efforts in the county. Since Arizona is among the first to try this approach, the counties in the state are providing ongoing evaluation of their efforts to the Arizona Department of Health Services. The concept is being tested as a whole. The PCHD conducts ongoing public health needs assessments as part of its mandate to report the health status of the County. Special attention will be paid to the neighborhood areas where services are provided under these contracts. Finally, PCHD will evaluate results seen from a systems perspective through the development of a matrix defining agency and provider linkages.

Barriers Encountered:	Strategies to Overcome:
Difficulty in recruiting consumers for advisory group membership from special communities. Need for contractors to approach service delivery design from a public health population based systems perspective and not just individual unit of service based on a medical model.	Devising incentive mechanisms and more active recruitment contacts are two strategies that will be tried to increase consumer participation on the Advisory Group. Providing outside consultation in the areas of strategic planning and evaluation as well as teaching the public health model as system from which to provide services.

Key Partners/ Collaborators:

Many community stakeholders: University of Arizona/University Physicians Incorporated, University of Arizona College of Nursing, University of Arizona Rural Health Office, Tucson Association for Child Care, Pima Health Systems, Access Blue Connection, St. Elizabeths of Hungary Clinic, La Frontera, United Community Health Center, Mercy Care Plan, The Parent Connection, Salud Para Todos, CODAC Behavioral Health Services, Birth and Women's Health Center

Accomplishments:

The first funding cycle is compete, RFPs were issued and reviewed, contracts were awarded, and contractors are offering services in their respective neighborhoods. All projects make extensive use of lay health outreach workers. Hundreds of women have been contacted in their homes. The advisory group continues to meet on a regular basis, and the contractors are also beginning to meet on a regular basis to share project updates and work on collaborative efforts as suggested by the advisory group.

Lessons Learned:

1. Taking risks/daring to do something a different way. In this case on many levels released us to share the control for improvement of health status.
    a) level 1 - Arizona legislature and Arizona Department of Health Services
    b) level 2 - Arizona Department of Health Services and local county health departments
    c) level 3 - Local health departments and the community stakeholders
2. Finding new ways to work with other county health departments in the state

* For complete listing of essential MCH functions and initiatives, refer to grid on pages 10-17.

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Safe Kids Coalition of McLennan County

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Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:
Develop tools standardizing data collection, analyses, reporting
Community perceptions or health problems/needs.
Hotlines, print materials, media campaigns.
Assessment of provider reports regarding process and outcomes.
Develop & promote MCH agenda & YR2000 National Objectives.
Staff training.
Provide outreach services.
Monitor enrollment practices for ease of use.
Identify high-risk/hard-to-reach populations.

MCH Initiatives:
Immunization.
Communicable diseases.
Overcoming cultural barriers.
Reducing transportation barriers.
Expanding private sector links.
School & health connections.
Building coalitions & partnerships.
Immunization tracking/recall.

Funding Sources:

Budget: $50,000

City/County/Local government funds.
General state funds.
Private source(s): McLennan County Medical Society

Description:

Not reported.

Objectives:

The number of reported cases of vaccine-preventable diseases will not exceed 12 cases per year. Outcome measure-weekly surveillance of schools, hospitals, doctor's office, etc.

Access to immunization services will be available daily. Outcome measure--1) monitor and increase the number of Vaccine for Children providers in the county, 2) provide services in non-traditional settings such as schools, churches, day care centers, etc.

Role of Local Health Department:

The Health District has been a key player in the development of the coalition. Planning began approximately five years ago. The program began as a way to help increase the immunization level of children in McLennan County. Staff from the Health District trained and worked with other community nurses and volunteers to provide immunizations to children in non-traditional settings. The program has now incorporated the Vaccine for Children aspect to include Private Physicians the ability to provide immunizations to their clients at no charge. It has also grown to work with other child safety issues such as the use of bike helmet and car safety seats. The Health District helps to provide data for evaluation, and review of such data community-wide.

Barriers Encountered:	Strategies to Overcome:
Decreasing number of volunteers to provide off-site services.	Community awareness of need for licensed and non-licensed volunteers.
Proper utilization of available services.	Client education and awareness of need for repeated visits.
Transportation to sites.	Having more sites in high risk (targeted) neighborhoods.
Language barrier.	Recruitment of bilingual volunteers.

Key Partners/ Collaborators:

Salvation Army
Local hospitals and physicians and clinics
McLennan County Youth Collaboration
McLennan County Medical Society & Alliance
Local Day Care Director
Local School district personnel
Camp Fire
Baylor University
American Red Cross
Texas Department of Health (Regional & State Offices)

Accomplishments:

There have not been any confirmed reported cases of vaccine preventable diseases to date.

The number of VFC providers has increased to 60 to date as compared to 30 at this time last year.

There has been an increase in the number of off-site clinics provided.

Community organizations have begun to work more closely together to assure the safety of our kids.

Lessons Learned:

The greatest lesson learned has been how to work effectively with other local agencies, as well as the public we serve. It takes time and effort to build trusting relationships with others who may have been deemed "the competition," however, it can happen. People need to be willing to listen and work as a team.

Use Your Power! Project

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E-mail:

Replicated Elsewhere?
No

Updated Profile?
Yes. 1996

Essential MCH Functions: Managed Care model contract & access issues.	**MCH Initiatives:** Managed care initiatives.

Funding Sources:

Budget: $150,000

Private source(s): Consumer Health Foundation
Other Federal funds.

Description:

The primary aim of the Use Your Power! project is to empower low-income families to get the health care they need. A joint effort of the National Health Law Program (NHeLP) and the D.C. Office of Maternal and Child Health (OMCH), the Project started with funding from the Consumer Health Foundation, in January 1997. The Use Your Power Parent Council is an extraordinary group of men and women, all of whom are current or former Medicaid recipients. Parent Council members come from across the city, with more than half from communities "east of the river," where there is intractable poverty and a heavy reliance on human services such as Medicaid. Many are residents of public housing and census tracts with the city's worst health indices. Members range in age from 19 to 55, include two Latinos and three single fathers. Many Parent Council members have already experienced the District's voluntary Medicaid managed care system and have had to negotiate seemingly insurmountable barriers to care for themselves and their families. Contrary to the view that it is impossible to engage Medicaid beneficiaries in this type of activity, the Use Your Power! Project has had enthusiastic and extensive participation at every scheduled meeting. This activity is an extension of OMCH's effort to address the issues of Medicaid managed care. In 1996, OMCH in conjunction with the D.C. Healthy Start Project produced a 30-minute video, Use Your Power!: The Key to the Highway of Health with Medicaid Managed Care. The video was developed from interviews with AFDC (now TANF) recipients and community groups.

Objectives:

To help District of Columbia parents access health care services for themselves and their children by providing them with education and the tools needed to negotiate the District's new Medicaid managed care system, and to empower parents to be effective advocates for themselves and other low-income families. Outcome measures include:

1. To develop culturally competent printed materials to accompany the Use Your Power! video and supplement the information supplied by Medicaid.
2. To recruit and train 15-20 parents in Medicaid managed care and leadership development.
3. To conduct at least 25 parent-led video workshops to consumers in community-based settings.
4. To coordinate at least five training workshops on Medicaid managed care to consumers.

Role of Local Health Department:

Building on the video released in 1996, OMCH established a Use Your Power! Project in collaboration with the National Health Law Program. OMCH with technical assistance from MCHB produced the first video of its kind and ensured extensive community distribution of the video. In addition to production responsibilities, many OMCH staff including our lay outreach workers appeared in the video. Jointly with the National Health Law Program, OMCH submitted a proposal to the Consumer Health Foundation, a local conversion foundation, to provide Medicaid managed care education and training and educational materials to supplement the video. Evaluation of the effort has been qualitative and obtained through focus groups, the Parent's Council and other community forums.

Barriers Encountered:	**Strategies to Overcome:**
Low-income families have not been involved in discussions about Medicaid managed care.	Providing parents with public speaking training and information about managed care.

Key Partners/ Collaborators:

The key partner is the National Health Law Program. The Medicaid Agency has collaborated on the video development and the Maternal and Child Health Bureau/HHS provided the initial technical assistance. The District of Columbia Healthy Start Project, another OMCH program, serves as the co-conveners and co-facilitators of the ongoing parent training.

Accomplishments:

1. A video, Use Your Power! The Keys to the Highway of Health with Medicaid Managed Care has been shown on cable-TV for well over six months and is now being shown at eligibility centers throughout the District of Columbia.

2. Parents made a presentation before Medicaid's Medical Care Advisory Committee (MAC) and invited to be the first recipient members of this powerful and mandated committee.

3. No parents have dropped out of the group and members continue to voice strong commitment to the effort. A 25-member Use Your Power! Parent Council has been created.

4. OMCH has strengthened its position with advocacy organizations such as AFFIRM and the Children's Health Coalition. Also, there are now monthly meetings between OMCH and Medicaid to discuss policy concerns.

Lessons Learned:

Local and state MCH agencies must take a leadership role to assist Medicaid clients to navigate the new service system. Without this leadership, families will not get the care they need.

Local and state MCH agencies have the experience with low-income populations that many other organizations do not have. We must ensure the competency of the public health and primary care workforce through provider education.

"How to Write a Successful Mini-Grant" Workshop

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E-mail:

Replicated Elsewhere?
No

Updated Profile?

Essential MCH Functions:	**MCH Initiatives:**
Development of models. Hotlines, print materials, media campaigns.	Not reported.

Funding Sources:

Budget: $10,000

Other Federal funds.

Description:

In April 1997, Northern Health Services (Public Health, in New Castle County) developed the Healthy Delaware 2000 Mini-Grant program using the DeKalb Small Grants Program model as a guide and inspiration. Experience had taught us that the small community-based agencies that we wanted to target were leery of making applications for grants because of a lack of understanding of the process, because they didn't have staff with grant writing skills, or they felt unable to compete against more sophisticated agencies, which frequently received the grants.

The solution was to invite the community to participate in a "How to Write a Successful Mini-Grant" Workshop. Thirty-five organizations of varying sizes and descriptions participated in the early evening workshop at the Public Safety Building in Wilmington. After a buffet dinner, attendees learned about the Healthy Delaware 2000 objectives, about the health problems of their communities and key strategies that had been identified for reducing risk. Four breakout sessions grouped participants into smaller "like" groups of agencies to review the process and work through a "mock" mini-grant application, developing objectives and action steps. Packets included a summary sheet on Healthy DE 2000, a worksheet on developing goals and objectives, a copy of the "mock" grant and a blank grant application.

The evaluations rated the workshop highly successful and 16 grant applications were received. Ten mini-grants were awarded of $1000 each for projects related to teen pregnancy.

Objectives:

1. Developing an interest in health issues at the local community level.
2. Reaching out to and educating small community agencies.
3. Meeting and working with a new group of community leaders.
4. Developing recognition of Public Health as a interested leader in the community.
5. Getting the health message out in a new way.

Role of Local Health Department:

Public Health, Northern Health Services developed the concept, planned and implemented the mini-grant workshop. Assistance was provided by state epidemiologist, and other program managers at the state level.

Barriers Encountered:	**Strategies to Overcome:**
Doing more without new resources to manage them. Reaching new agencies or community groups.	Reallocate part of a position to manage. Press release to advertise the workshop. Diamond Net (State of De Intranet) Networking among agencies.

Key Partners/ Collaborators:

The local agencies involved will be partners in the evaluation of the project. Another round of mini-grants is planned.

Accomplishments:

1. The workshop itself was a successful vehicle for educating people in the community about the health problems and the concept of communities developing their own strategies for reduction of risk.
2. The workshop reached about thirty-five small community organizations, some of whom Public Health had not had prior contact.
3. Ten mini-grants were awarded and ten projects are in progress.
4. The News Journal visited one project for interviews and photos.
5. Calls from other community agencies have been received asking to be part of the next round of mini-grants to be awarded.
6. Public Health has received more recognition in the community.

Lessons Learned:

Working with the very small communities groups is very time intensive. A lot of education and support is needed to help find the resources needed to provide programs. The person who is in charge of this type of mini-grant program must be willing to put a lot of effort into supporting these small groups in order to develop their potential. Even with a lot of education and guidance, some agencies may not have the capability to put an application together and run a program. However, some agencies are an untapped resource waiting to be discovered, and offer opportunities to reach others in the community.

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CityMatCH Membership List

FEDERAL REGION I: CT, MA, ME, NH, RI, VT

Connecticut

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Lessons Learned 1997

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